Universal Referral Form
for Early Intervention/Early Childhood Special Education (EI/ECSE) Providers*

CHILD/PARENT CONTACT INFORMATION

Child's Name: _____ Date of Birth: _____/_____/_____

Parent/Guardian Name: _____ Relationship to the Child: _____

Address: _____City: _____ State: _____ Zip: _____

County: _____ Primary Phone: _____ Secondary Phone: _____ E-mail: _____

Primary Language: _____ Interpreter Needed: ☐Yes ☐ No

Type of Insurance:

☐ Private ☐OHP/Medicaid ☐TRICARE/Other Military Ins. ☐Other (Specify)_____ ☐ No insurance

Child's Doctor's Name, Location And Phone (if known): _____

PARENT CONSENT FOR RELEASE OF INFORMATION (more about this consent on page 4)

Consent for release of medical and educational information

I, _____ (print name of parent or guardian), give permission for my child's health provider _____ (print provider's name), to share any and all pertinent information regarding my child, _____ (print child's name), with Early Intervention/Early Childhood Special Education (EI/ECSE) services. I also give permission for EI/ECSE to share developmental and educational information regarding my child with the child health provider who referred my child to ensure they are informed of the results of the evaluation.

Parent/Guardian Signature: _____ **Date:** _____/_____/_____

Your consent is effective for a period of one year from the date of your signature on this release.

OFFICE USE ONLY BELOW:

Please fax or scan and send this Referral Form (front and back, if needed) to the EI/ECSE Services in the child's ***county of residence***

REASON FOR REFERRAL TO EI/ECSE SERVICES

Provider: Complete all that applies. Please attach completed screening tool.

Concerning screen: ☐ ASQ ☐ASQ:SE ☐ PEDS ☐PEDS:DM ☐M-CHAT ☐Other:_____

Concerns for possible delays in the following areas (please check all areas of concern and provide scores, where applicable):

☐Speech/Language _____ ☐Gross Motor_____ ☐ Fine Motor _____

☐ Adaptive/Self-Help _____ ☐Hearing _____ ☐ Vision _____

☐ Cognitive/Problem-Solving _____ ☐Social-Emotional or Behavior_____ ☐Other: _____

☐ Clinician concerns but not screened: _____

☐ Family is aware of reason for referral.

Provider Signature: _____ **Date:** _____/_____/_____

If a child under 3 has a physical or mental condition that is likely to result in a developmental delay, a qualified Physician, Physician Assistant, or Nurse Practitioner may refer the child by completing and signing the Medical Statement for Early Intervention Eligibility (reverse) in addition to this form.

PROVIDER INFORMATION AND REQUEST FOR REFERRAL RESULTS

Name and title of provider making referral: _____ Office Phone: _____ Office Fax: _____

Address: _____City: _____ State: _____ Zip: _____

Are you the child's Primary Care Physician (PCP)? Y___ N___ If not, please enter name of PCP if known: _____

I request the following information to include in the child's health records:

☐ Evaluation Report ☐Eligibility Statement ☐ Individual Family Service Plan (IFSP)

☐ Early Intervention/Early Childhood Special Education Brochure ☐ Evaluation Results

EI/ECSE EVALUATION RESULTS TO REFERRING PROVIDER

EI/ESCE Services: ***please complete this portion, attach requested information, and return to the referral source above.***

☐Family contacted on _____/_____/_____ The child was evaluated on _____/_____/_____ and was found to be:

☐Eligible for services ☐Not eligible for services at this time, referred to: _____

EI/ECSE County Contact/Phone: _____ Notes:_____

Attachments as requested above: :_____

☐Unable to contact parent ☐ Unable to complete evaluation EI/ECSE will close referral on _____/_____/_____.

* The EI/ECSE Referral Form may be duplicated and downloaded from the ABCD Child Health Provider Toolkit website: http://1.usa.gov/JLvXHv

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MEDICAL CONDITION STATEMENT FOR EARLY INTERVENTION ELIGIBILITY (BIRTH TO AGE 3)

Date: _____ Child's Name: _____ Birthdate: _____

The State of Oregon, through the Oregon Department of Education, provides services to young children with significant developmental problems. The Department recognizes that disabilities may not be evident as delays in infants and very young children, but, without intervention, the child will become developmentally delayed.

The above named child may have such a condition. Oregon law requires that a physician, physician assistant, or nurse practitioner with the appropriate State Board licensure, examine the child and determine whether the child has a physical or mental condition that is likely to result in a developmental delay.

The Oregon Department of Education requests your assistance in determining this child's eligibility for Early Intervention (EI) services. While many children may benefit from EI services, please understand that this program has been established to serve only those infants and young children in whom developmental delays are evident or likely to develop.

Medical Condition:

_____

_____

_____

Please indicate if this child has a:

Vision Impairment
Hearing Impairment
Orthopedic Impairment

Comments:

_____

_____

_____

Yes	No	This child has a physical or mental condition that is likely to result in a developmental delay.

_____ _____
Physician/Physician Assistant/Nurse Practitioner Date

Oregon law requires that a physician, physician assistant, or nurse practitioner, with the appropriate State Board licensure determine whether the child has a physical or mental condition that is likely to result in a developmental delay. For a physician and physician assistant this licensure in Oregon is from the State Board of Medical Examiners. For a nurse practitioner in Oregon this licensure is from the State Board of Nursing. Physicians, physician assistants, and nurse practitioners from other states must have the appropriate requisite licensure for their State. This form is used by the physician, physician assistant, or nurse practitioner to indicate the child's diagnosis for special education purposes.

Print Name: _____ Phone: _____

Please return to: _____

_____

_____

_____

_____

Submit this with EI/ECSE Referral Form to the EI/ECSE program in the child's county of residence.

Copies of this form (Form 581-5150D-X (4/12)) may be obtained from the Oregon Department of Education, Early Intervention/Early Childhood Special Education

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or on-line at http://www.ode.state.or.us/search/page/?=3166

OREGON EI/ECSE CONTACTS

Baker County Phone: 800.927.5847	**Douglas County** Phone: 541.440.4794 Fax: 541.440.4771	**Lake County** Phone: 541.947.3371 Fax: 541.947.3373	**Sherman County** Phone: 541.565.3600 Fax: 541.565.3640
Benton County 877.589.9751 Phone: 541.753.1202 x106 Fax: 541.926.6047	**Gilliam County** Phone: 541.565.3600 Fax: 541.565.3640	**Lane County** 800.925.8694 Phone: 541.346.2578 Fax: 541.346.6189	**Tillamook County** Phone: 503.842.8423 Fax: 503.842.6272
Clackamas County Phone: 503.675.4097 Fax: 503.675.4205	**Grant County** Phone: 800.927.5847	**Lincoln County** Phone: 541.574.2240 x100 Fax: 541.265.6490	**Umatilla County** Phone: 800.927.5847
Clatsop County Phone: 503.338.3368 Fax: 503.325.1297	**Harney County** Phone: 541.573.6461 Fax: 541.573.1914	**Linn County** Phone: 541.753.1202 x106 877.589.9751 Fax: 541.926.6047	**Union County** Phone: 800.927.5847
Columbia County Phone: 503.366.4141 Fax: 503.397.0796	**Hood River County** Phone: 541.386.4919 Fax: 541.387.5041	**Malheur County** Phone: 541.372.2214 Fax: 541.372.2214	**Wallowa County** Phone: 541.426.7641 Fax: 541.426.3732
Coos County Phone: 541.269.4524 Fax: 541.269.4548	**Jackson County** Phone: 541.494.7800 Fax: 541.494.7829	**Marion County** 888.560.4666 Phone: 503.385.4714 Fax: 503.435.5922	**Warm Springs** Phone: 541.553.3241 Fax: 541.553.3379
Crook County Phone: 541.312.1195 Fax: 541.382.3901	**Jefferson County** Phone: 541.693.5740 Fax: 541.475.5337	**Morrow County** Phone: 800.927.5847	**Wasco County** Phone: 541.296.1478 Fax: 541.296.3451
Curry County Phone: 541.269.4524 Fax: 541.269.4548	**Josephine County** Phone: 541.956.2059 Fax: 541.956.1704	**Multnomah County** Phone: 503.261.5535 Fax: 503.894.8229	**Washington County** English: 503.614.1446 Spanish: 503.614.1263 Fax: 503.614.1290
Deschutes County Phone: 541.312.1195 Fax: 541.382.3901	**Klamath County** Phone: 541.883.4748 Fax: 541.850.2770	**Polk County** Phone: 503.435.5918 Fax: 503.435.5922	**Wheeler County** Phone: 541.565.3600 Fax: 541.565.3640
Oregon EI/ECSE contact information also available at **www.ode.state.or.us/search/page/?id=1690** **or contact 1-800-SafeNet**			**Yamhill County** Phone: 503.435.5918 Fax: 503.435.5922

For questions or corrections about this form, contact the
Oregon Public Health Division, Center for Prevention and Health Promotion:
molly.emmons@state.or.us or 971-673-0234

This EI/ECSE Referral Form may be duplicated and downloaded at

http://1.usa.gov/JLvXHv

Form Rev. 09/25/2012

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN HEALTHCARE PROVIDERS and EARLY INTERVENTION

Information for Parents

This consent for release of information authorizes the disclosure and/or use of your child's health information from your child's health care provider to the Early Intervention/Early Childhood Special Education (EI/ECSE) program. This consent form also authorizes the disclosure of developmental and educational information from the Early Intervention/Early Childhood Special Education program to your child's health care provider.

Why is this consent form important?

Your child's health care provider sees your child at well-child screening visits and for medical treatment. Sometimes your child's health care provider may see the need for more information, like evaluation or follow up by other specialists, to identify your child's special health care needs. The Early Intervention/Early Childhood Special Education (EI/ECSE) program can be a resource to help identify your child's needs. The primary goal of this consent form is to allow communication between your child's health care provider and EI/ECSE programs so these providers can work together to help your child.

Why am I asked to sign a consent on this form?

The consent allows your child's health care provider to share information about your child with EI/ECSE, and allows EI/ECSE to share information about your child with your health care provider. Your consent for the release of information allows your child's health care provider and EI/ECSE communicate with one another to ensure your child gets the care your child needs. However, as your child's parent or legal guardian you may refuse to give consent to this release of information.

How will this consent be used?

This consent form will follow your child as he/she is screened and/or evaluated at EI/ECSE. The information generated by this release will become a part of your child's medical and educational records. Information will be shared with only individuals working at or with EI/ECSE or the office of your child's health care provider for the purpose of providing safe, appropriate and least restrictive educational settings and services and for coordinating appropriate health care.

How long is the consent good for?

This consent is effective for a period of one year from the date of your signature on the release.

What are my rights?

You have the following rights with respect to this consent:

- You may revoke this consent at anytime.
- You have the right to receive a copy of the Authorization.