

Referral Form

# The parent/guardian must be aware of this referral before Help Me Grow staff contact them. You are required to obtain permission from the caregiver before submitting a referral.

**Child Information**

Prenatal referral?  yes no Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child Name (First & Last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postpartum and any current challenges? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name (First & Last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: City: State: Zip:

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best Time to Contact:  Morning  Afternoon

Email: Preferred mode of contact:  Phone  Text Email

Language spoken at home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Race:

American Indian or Alaskan Native  White

Asian  More than one race

Black/African American  Other: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Native Hawaiian/Other Pacific Islander  Declined to answer

Child Ethnicity: Hispanic/Latino? yes  no

**Reason for Referral**

Children’s Integrated Services (CIS) for:

Early intervention

Home visiting

Mental health services

Perinatal mental health treatment and supports

Treatment and supports for substance use disorder during pregnancy

Childcare, preschool, Head Start, playgroups, parenting classes and more

WIC and resources for basic needs

**Referring Provider Information**

Person/Agency/Practice requesting referral:

First/Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Insurance:**  Medicaid/Dr. Dynasaur  Private Insurance Both Private and Medicaid  Uninsured  Unknown

Has a developmental screening tool like the ASQ-3 been completed? yes  no

**By signing below, I authorize that the parent/guardian has given permission for information on this** **form and any accompanying support documents to be shared with Help Me Grow and Children’s Integrated Services.**

Signature

Date

Please fax this form to 802-861-2544.

Questions? Dial 2-1-1 x6 to reach a *Help Me Grow* Child Development Specialist.

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