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.

www.helpmegrowvt.org | info@helpmegrowvt.org