

SoonerStart Early Intervention Referral

(Page 1 for medical practitioner office use)

This referral form is to be used to refer a potentially eligible infant or toddler (birth to 36 months) to the **SoonerStart Early Intervention Program**. If you have concerns that the child has one or more of the conditions listed, you should consider referring the child to the SoonerStart program.

Parent/Child Contact Information

(Patient Sticker Information or Fill in the blanks)

Child Name: _____ Parent/Guardian _____
Date of Birth: ____/____/____ Child Age: (Months) _____ Phone: _____ (Home) _____ (Other) _____
Home Address: _____ Primary Language _____
Physician _____ Gender: M or F
Medical Record # _____ Provider _____

Reason(s) for Referral to Early Intervention

(Please check all of the following that apply)

Known condition or diagnosis* (e.g., Autism, cerebral palsy, Down syndrome, failure to thrive, spina bifida, etc.) _____

*** NOTE: Diagnosis of a specific condition or disorder is not necessary for a referral.**

At-risk (e.g., low birth weight, parental concern, prematurity, etc.): _____

Suspected developmental delay or concern (Please circle areas of concern):

Motor/Physical Cognitive Social/Emotional Speech/Language Behavior Other: _____

Formal screening tool identified concerns (e.g. Ages and Stages – ASQ, Parents Evaluation of Developmental Status – PEDS, etc.) → Results attached

Other (Describe): _____

Not all eligible conditions are listed on this form. A complete list can be found online at: <http://se.sde.state.ok.us/ses/preschool/publications/eimanual.pdf>

Referral Source Contact Information

Facility/Clinic/Organization name _____ Date of Referral ____/____/____
Address _____ City _____ State _____ Zip _____
Phone Number _____ Fax Number _____
Name of health care provider making referral _____

Request for Referral to Sooner Start

I, _____ (Print name of parent or guardian), give my permission for the health care provider named above to share any and all pertinent health information regarding my child, _____ (print name) with the SoonerStart Early Intervention Program.

Parent/Legal Guardian Signature _____ Date: ____/____/____

(____) I have received Notices of Privacy Practices as required by HIPAA regarding how this protected health information may be used and disclosed and how I can access that information.

Please FAX both pages of this form to your Regional Office (and contact them with any questions, comments or concerns regarding the information on either page).

Regional Office: _____
Address: _____
Phone: _____ Fax: _____

Child Referral Status Information

(Page 2 For SoonerStart personnel use)

Parent/Child Contact Information

(Patient Sticker Information or Fill in the blanks)

Child Name: _____ Parent/Guardian _____
Date of Birth: ____/____/____ Child Age: (Months) _____ Phone: _____ (Home) _____ (Other) _____
Home Address: _____ Primary Language _____
Physician _____ Social Sec.# _____ - _____ - _____ Gender: **M** or **F**
Medical Record # _____ Provider _____

Results of Contact Attempts

At this time, the following information is true and correct in regard to the referral made for the above named child:

_____ **Unable to locate and/or contact this family with the information provided; please check and resubmit the referral**

_____ **Family successfully contacted; parent declined to authorize SoonerStart to begin services.**

_____ **Family successfully contacted; results will follow in another fax.**

_____ **Family successfully contacted; results of encounter:** _____

Results of Screening/Evaluation

Information to share **with** referral source:

_____ **Evaluation completed; child did NOT meet eligibility criteria and WAS NOT enrolled for services**

_____ **Evaluation completed; child found eligible for services; family/caretaker declined enrollment**

_____ **Evaluation completed; child met eligibility requirements for early intervention services and WAS enrolled in services**

_____ **Individualized Family Service Plan (IFSP) completed; early intervention services in progress**

Services child will receive and date services are tentatively scheduled to begin:

OT _____ **PT** _____ **SLP** _____ **Nutrition** _____ **Case coordination** _____ **Other:** _____
(date) (date) (date) (date) (date) (date)

Documents included with this return information:

_____ **Screening Results:** _____ **Ages and Stages Questionnaire (ASQ)**
_____ **Ages and Stages Questionnaire-Socioemotional (ASQ-SE)**
_____ **Other:** _____

_____ **Evaluation Results:** _____ **Multidisciplinary Evaluation and Treatment Summary (METS)**
_____ **Battelle Developmental Inventory, 2nd ed. (BDI-2)**
_____ **Other:** _____

_____ **Individualized Family Service Plan (IFSP)**

Person completing this form: _____ Date _____
(signature)

Resource Coordinator Information

Assigned Resource Coordinator (RC): _____

Resource Coordinator (RC) contact number: _____