

Early Intervention/Early Childhood Special Education (EI/ECSE) Referral Form for Providers* Birth to Age 5

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 child has an identified condition or diagnosis known to have a high probability of resulting in significant delays in development, please complete the attached Physician Statement for Early Intervention Eligibility (on reverse) in addition to this referral form. Only a physician licensed by a State Board of Medical Examiners may sign the Physician Statement.

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/ECSE 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/ILvXHv>
Form Rev. 06/20/2012

**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

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 x106 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: 541.296.2965 | 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: 541.269.4524 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: 503.262.4100 Fax: 503.262.4109 | 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: 503.435.5940 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, Office of Family Health:
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>

Early Intervention/Early Childhood Special Education (EI/ECSE) Referral Form for Providers* Birth to Age 5

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.