

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: _____
Text Acceptable: Yes No Best Time to Contact: _____
Primary Language: _____ Interpreter Needed: Yes No

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 M-CHAT Other: _____
Concerns for possible delays in the following areas (please check all areas of concern and provide scores, where applicable):
 Communication _____ Fine Motor _____ Personal Social _____
 Gross Motor _____ Problem Solving _____ Other: _____
 Clinician concerns (including vision and hearing) 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

Referring Provider Name: _____ Referral Contact Person: _____
Office Phone: _____ Office Fax: _____ Address: _____

City: _____ State: _____ Zip: _____
Primary Care Provider: _____
If the child is eligible, medical provider will receive a copy of the Service Summary.

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: _____
 Parent Declined Evaluation Parent Does Not Have Concerns
 Unable to contact parent Attempts _____ EI/ECSE will close referral on ____/____/____.

* The EI/ECSE Referral Form may be duplicated and downloaded at this Oregon Department of Education [web page](#).

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 (ODE), provides Early Intervention (EI) services to infants and young children ages birth to three with significant developmental delays. ODE recognizes that disabilities may not be evident in every young child, but without intervention, there is a strong likelihood a child with unrecognized disabilities may become developmentally delayed.

ODE is requesting your assistance in determining eligibility for Oregon EI services for the child named above. Under Oregon law, a physician, physician assistant, or nurse practitioner licensed in by the appropriate State Board can examine a child and make a determination as to whether he or she has a physical or mental condition that is likely to result in a developmental delay.

Please keep in mind that, while many children may benefit from Oregon's EI services, only those in whom significant developmental delays are evident or very likely to develop are eligible.

Thank you for your time and assistance with this matter.

Medical Condition:

Please indicate if this child has a:

- Vision Impairment
- Hearing Impairment
- Orthopedic Impairment

Comments:

Yes <input type="checkbox"/>	No <input type="checkbox"/>	This child has a physical or mental condition that is likely to result in a developmental delay.
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Physician/Physician Assistant/Nurse Practitioner

Date

Print Name: _____ Phone: _____

OREGON EI/ECSE CONTACTS

Baker County Phone: 800.927.5847 Fax: 541.276.4252	Douglas County Phone: 541.440.4794 Fax: 541.440.4799	Lake County Phone: 541.947.3371 Fax: 541.947.3373	Sherman County Phone: 541.238.6988 Fax: 541.384.2752
Benton County Phone: 541.753.1202 x106 877.589.9751 Fax: 541.753.1139	Gilliam County Phone: 541.238.6988 Fax: 541.384.2752	Lane County 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 Fax: 541.276.4252	Lincoln County Phone: 541.574.2240 x101 Fax: 541.265.6490	Umatilla County Phone: 800.927.5847 Fax: 541.276.4252
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: 541.753.1139	Union County Phone: 800.927.5847 Fax: 541.276.4252
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: 541.473.3915	Wallowa County Phone: 541.927.5847 Fax: 541.276.4252
Coos County Phone: 541.269.4524 Fax: 541.269.4548	Jackson County Phone: 541.494.7800 Fax: 541.494.7829	Marion County Phone: 503.385.4714 888-560-4666 x4714 Fax: 503.540.2959	Warm Springs Phone: 541.553.3241 Fax: 541.553.3379
Crook County Phone: 541.693.5630 Fax: 541.693.5661	Jefferson County Phone: 541.693.5740 Fax: 541.475.5337	Morrow County Phone: 800.927.5847 Fax: 541.276.4252	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: 503.614.1299 Fax: 503.614.1290
Deschutes County Phone: 541.312.1195 Fax: 541.693.5661	Klamath County Phone: 541.883.4748 Fax: 541.850.2770	Polk County Phone: 503.385.4714 888-560-4666 x4714 Fax: 503.540.2959	Wheeler County Phone: 541.238.6988 Fax: 541.384.2752
			Yamhill County Phone: 503.385.4714 888-560-4666 x4714 Fax: 503.540.2959

EI/ECSE contact information also available at this Oregon Department of Education [web page](#).

or please call 1-800-SafeNet

SOUTHWEST WASHINGTON EI/ECSE CONTACTS

(NOTE: EI/ECSE Program Requirements differ in each state; please contact these offices for Washington Requirements)

Clark County Phone: 360.896.9912 ext.170 Fax: 360.892.3209	Cowlitz County Phone: 360.425.9810 Fax: 360.425.1053	Klickitat County Phone: 360.921.2309 Fax: 509.493.2204	Skamania County Phone: 509.427.3865 Fax: 509.427.4430
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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.