Early Intervention Colorado Referral and Release Form

For Infants and Toddlers- Birth through Two Years of Age Who May Need Early Intervention Services

Referral Information

Community Centered Board: _____ **Fax:** _____

Child's Name: _____ ☐ Boy ☐ Girl DOB: _____

Parent(s)/Legal Guardian: _____ Phone: _____

Family's Address: _____ County: _____

Family's E-mail: _____ Alt Phone: _____

Primary Language Spoken by Parent(s)/Legal Guardian/Foster Parents: ☐ English ☐ Spanish ☐ Other _____

Primary Care Physician (PCP): _____ PCP E-mail: _____ Phone: _____

DHS REFERRALS ONLY CAPTA? ☐ YES ☐ NO

Legal Status of child:
☐ Biological parent custody, rights intact ☐ Foster/Kinship care, biological rights intact ☐ Foster/Kinship care, parent rights terminated

Foster/Kinship Parent(s) (if applicable): _____ **Phone:** _____

Foster/Kinship Parent(s) Address: _____ County: _____

How long has child resided at this residence? _____ Surrogate/ Advocate/ Guardian ad Litem? ☐ YES ☐ NO

If yes, Name: _____ Phone: _____

Assigned DSS Caseworker: _____ Phone: _____

E-mail: _____ Case open? ☐ YES ☐ NO

Guardian ad Litem (GAL) Name: _____ Phone: _____

GAL E-mail: _____ Educational Decision-making authority? ☐ YES ☐ NO

Referring Practice/Agency: _____ Referring Person: _____

Referring Person Phone: _____ Referring Person Fax: _____

Referring Person E-mail: _____

Are you a Qualified Health Professional? *(See referral source guide for list)* ☐ YES ☐ NO If yes, Discipline: _____

Person to send referral status update to; if different: _____ Fax, if different: _____

Has a developmental screening been completed for this child? ☐ YES ☐ NO **If *yes, send the screening results with the referral.***

Please check and complete one of the following boxes (**A** or **B**):

A. ☐ **This child has been diagnosed with the following physical or mental condition(s) known to have a high probability of resulting in significant delays in development (*even if no delays are apparent at this time*):**

_____

(See the Established Condition Database located at www.eicolorado.org for a complete list of qualifying diagnoses.)

B. ☐ **There are concerns for possible delays in development in the following area(s):** _____

Signed: _____ (referring person) Date of Referral: _____

Authorization to Release Information (optional)

I authorize the Community Centered Board Early Intervention Colorado Program to share the following information with the referring practice/agency listed above.

- ☐ Eligibility outcome information (eligible/not eligible)
- ☐ Evaluation/Assessment results (range of delay for each developmental domain)
- ☐ Ongoing Early Intervention Services included on the Individualized Family Service Plan for the purpose of care coordination.

I understand that I may withdraw this consent by written request to the Community Centered Board Early Intervention Colorado Program. If consent is revoked it does not apply to any actions that occurred before consent was revoked.

I certify that this authorization to release this information has been given freely and voluntarily. Information collected related to early intervention services may not be shared unless the person who consented to sharing this information specifically consents to it and or the sharing this information is allowed by law. I understand I have a right to inspect and copy the information to be disclosed.

Signed: _____ Date: _____

(child's parent or legal guardian)

*Authorization is effective for a period of 12 months from this date

For more information call 1-888-777-4041 or visit www.eicolorado.org **1/2014**