**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: North Metro Community Services Fax: \_303-452-5112**\_

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:

|  |  |  |  |
| --- | --- | --- | --- |
| Foster Parent(s) (if applicable): |  | Phone: |  |
| Foster 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 | CAPTA? YES NO |
| Legal Status of child Parental custody, rights intact Foster care, biological rights intact Foster care, parent rights terminated | | | |
| Other/Explain: | | | |

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**):

1. **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*](http://www.eicolorado.org/) *for a complete list of qualifying diagnoses.)*

# 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)
* Early Intervention Services included on the Individualized Family Service Plan, including frequency and intensity

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***](http://www.eicolorado.org/)**5/2012**