Directions for Use of FDLRS/Child Find Referral Form

Referred By: Fill in Name of Your Facility (*Child Care Facility*) **Director's Name:** Enter Director's Name (*Director's Name*)

Facility E-Mail: Facility E-mail **Phone#:** Facility phone number **FAX #:** Facility Fax Number

Referring Source: **ELC BROWARD** **ASQ3/SE Attached:** ❑ Y ❑ N ❑ New ❑ Annual

Authorization to Refer: Print Name of Parent or Guardian (*Print Parent/Custodial Caregiver's Name*) Have Parent/Guardian Sign Here (*Signature*) Relationship to Child (*Relationship*) Today's Date (*Date:*)

Child's Name: Child's Name **DOB:** Date of Birth **Age:** Child's Age

Sex: ❑ M ❑ F **Language Spoken at Home:** Home Language Family receives SR financial assistance? ❑ Y ❑ N
Complete accordingly

❑ Parent ❑ Foster Parent ❑ Relative ❑ Guardian: Check correct box & Put Name of Person here

Home Address: Person's Address Apt #: Person's Apartment #

City: Person's City State: FL Zip Person's Zip Code

Home Phone: 954/754 Place Phone # Here Work: 954/754 Place Phone # Here Cell: 954/754 Place Phone # Here

Alternative Contact Name: Put Name of Adult Here Relationship: Other Adult's Relationship to Child Phone: Place Phone # Here

Please fill in this information by checking the appropriate boxes and entering the names and numbers (for children under 3 ONLY)
Child Covered by Healthcare Insurance? ❑ Y ❑ N ❑ Unknown Medicaid #: ____________
Private: ❑ Y ❑ N Name of Insurance Plan: ____________ Plan #: ____________

If the child is receiving Protective Services, check the yes box below. To determine if a child is receiving Protective Services, locate the "Child Care Certificate" from Family Central. Find the "Eligibility" field. If a BG1 code is entered, check the yes box on this form, as the child is receiving Protective Services.

Child is currently receiving Protective Service: ❑ Y ❑ N Child Net Advocate: Add name if known

Please Fill in the Squares by Checking the Appropriate Boxes

Developmental / Educational Concerns: ❑ Communication ❑ Motor ❑ Self-Help ❑ Cognitive ❑ Social/Emotional
❑ Behavioral ❑ Other: ____________

Please Fill in the Squares by Checking the Appropriate Boxes

Currently Receiving Developmental Services? ❑ Y ❑ N ❑ Physical Therapy ❑ Speech Therapy ❑ Occupational Therapy
❑ Behavioral Services ❑ Unknown Where? Add if known

Please Fill in the Squares by Checking the Appropriate Boxes

Child has a Medical Diagnosis ❑ Y ❑ N What?: Add if known

Comments ____________

BOXES BELOW FOR OFFICE USE ONLY

FOR FDLRS/CHILD FIND USE ONLY	FOR CDTC USE ONLY / PART C STATUS
FDLRS #: ____________	Part C Eligible ❑ Y ❑ N Date: ____________
Date of Referral: ____________	Service Coordinator: ____________
Home School: ____________	Initial IFSP: ____________
Screening Appointment: ____________	Transition IFSP Mtg.: ____________

Fax This Completed Form with ASQ-3 and ASQ-SE Summary Sheets To: FDLRS/Child Find 754-321-7217

Phone: 754-321-7200