Infants and Toddlers Birth to 36 months

Referral To

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San Bernardino County   Bilingual/Riverside County

Phone: (909) 890-4711   Phone: (909) 890-4763

Fax: (909) 890-4709   Fax: (909) 890-3055

DATE: _____

Referred By:

Name: _____ Title: _____

Name of Hospital, Clinic or County Office: _____

Address: _____

_____

Phone: (_____)_____ Fax/E-mail: _____

Infant/Toddler Name: _____

DOB: _____ Male ☐ Female ☐   Court Dependent: Yes ☐   No ☐

Biological Parent's name: _____

Address: _____

Phone: Home (_____)_____

Cell (_____)_____

Language: ☐ English   ☐ Spanish   Other:

Foster Parent/Guardian Name(s): _____

Address: _____

Phone: Home (_____)_____

Cell (_____)_____

Language: ☐ English   ☐ Spanish   Other: _____

Insurance: _____

REASON FOR REFERRAL

Instructions For Completing Your Referral (*Complete one, two or all SECTIONS as applicable*)

☐ **SECTION I**: I have attached the *Developmental Questionnaire*, *Section I*, to this referral. *Section I* is completed for ALL referrals for infants and toddlers where developmental delay is suspected WITHOUT a known contributing medical risk factor

☐ **SECTION II** I have attached the *Medical Questionnaire*, *Section II*, to this referral. *Section II* is completed for ALL referrals for infants and toddlers with known medical risk factors

☐ **SECTION III** I have attached the *Parent/Provider Questionnaire* for parents with developmental disabilities requesting services for their infant/toddler. (Care providers may also refer under this category)

DETAILED INFORMATION ALLOWS THE EARLY START STAFF TO FULLY UNDERSTAND THE REASON FOR YOUR REFERRAL AND EXPEDITE THE INTAKE EVALUATION PROCESS. IF NECESSARY, A MEMBER OF THE EARLY START STAFF WILL CONTACT YOU TO OBTAIN ADDITIONAL INFORMATION.

☐ ***SECTION I*** (DEVELOPMENTAL QUESTIONAIRRE)

Check primary reason(s) for concern:

☐*Physical/Gross Motor*   ☐*Fine Motor*   ☐*Adaptive/Self Help*   ☐*Cognitive/Thinking*
☐*Communication/Speech*   ☐*Social/Emotional*   ☐*Vision Impairment*   ☐*Hearing impairment*

DEVELOPMENTAL QUESTIONAIRRE						
Please respond by checking <u>Yes</u> or <u>No</u> to ALL questions within the developmental domain of concern *If Autism Spectrum Disorder is suspected (complete minimum of Social/Emotional, Cognitive/Thinking & Communication/Speech Domains)*					
Physical/Gross Motor	Yes	No	Communication/Speech	Yes	No
Lifts head 90 degrees while on tummy			Laughs		
Rolls over			Babbles		
Supported: Bears weight on legs			Imitates speech sounds eg.,raspberries		
Sits: No support			Follows direction: verbal cue alone		
Gets to sitting			Says mama and papa specific		
Crawls			Responds to name when called		
Pulls to stand			Uses words to communicate #_____		
Cruises holding on			Points to picture when named		
Takes steps with one hand held			Points to 3 body parts when named		
Stands alone			Uses two-word phrases		
Walks unsupported			Imitates new words		
Displays normal muscle tone			Social/Emotional	Yes	No
Has equal movements bilaterally			Quiets/comforts when held		
Fine Motor	Yes	No	Maintains periods of eye contact		
Brings hands together			Smiles at mirror image		
Reaches and grasps objects			Laughs during social game; peek-a-boo		
Grasp small object with thumb & finger			Offers/shares toy with adult		
Drops object into container on request			Initiates ball play or social game		
Holds large crayon & scribbles			Points to object to indicate interest		
Turns pages in book one by one			Shows interest in other children		
Adaptive/Self Help	Yes	No	Imitates domestic activities eg, sweeping		
Finger feeds			Engages in pretend play eg, on phone		
Drinks from open cup			Cognitive/Thinking	Yes	No
Uses spoon			Imitates adult: facial expression		
			Looks for completely hidden object		

Hearing Concern? Yes ☐ No ☐   **Vision Concern? Yes ☐ No ☐**

Tested? Date: _____ Result:_____   **Tested? Date: _____ Result:_____**

Comments:_____

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☐ *SECTION II (*MEDICAL QUESTIONAIRRE)

MEDICAL QUESTIONARRIRE			
No single risk factor or any combination of risk factors, will necessarily make a child eligible. Consideration is given to the combination and severity of medical risk factors			
Yes	No	Risk Factors:	Additional Information:
		Prematurity less than 32 weeks gestation and/or low birth weight of less than 1500 grams	Gestation (weeks): _____ Birth Weight: _____
		Assisted ventilation for 48 hours or longer during the first 28 days of life	# of Days:_____
		Small for gestation age: below the third percentile for estimated gestational age on growth charts	Gestational age:_____ Birth weight:_____
		Asphyxia Neonatorum associated with a five minute APGAR score of 0 to 5	APGAR 1 minute:_____ 5 minutes:_____
		Severe & persistent metabolic abnormality, including but not limited to hypoglycemia, acidemia, & hyperbilirubinemia (more than 20 mg/dl)	Highest bilirubin level:_____
		Neonatal Seizures or nonfebrile seizures	Anticonvulsant? Yes ☐ No ☐ _____
		Central nervous system lesion or abnormality	Describe:
		Central nervous system infection	Describe:
		Biochemical insult including, but not limited to, injury, accident or illness which may seriously or permanently affect developmental outcome	Describe:
		Multiple congenital anomalies or genetic disorders which may affect developmental outcome	Describe:
		Prenatal exposure to teratogens	Describe:
		Prenatal substance exposure, positive infant toxicology screen or symptomatic toxicity or withdrawal	Describe:
		Clinically significant failure to thrive, including but not limited to, weight persistently below 3rd percentile for age on growth chart or less than 85% of the ideal weight for age and/or acute weight loss or failure to gain weight with the loss of two or more major percentiles on the growth curve	Describe:
		Persistent muscle tone abnormality beyond that associated with a known condition	Describe:

☐ *__SECTION III__* (**Parent with developmental disability questionnaire**)

Yes	No	Risk Factor:	
		Parent with a developmental disability requests services for their infant/toddler	Parent is IRC consumer? Yes ☐ No ☐

ADDITIONAL COMMENTS:

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