Early Intervention / Preschool Special Education

Referral Results Form

Please return by fax to the student's primary clinic.

Student's Name_____ Gender M F DOB_____

Referral Source_____ Referral Date_____

Clinic or Referral Source Fax # _____ School District_____

Student's Primary Clinic_____ Date Faxed_____

EI/School District Contact Person_____ Phone_____

Outcome of the Referral: Check as many as apply

- ☐ Team was unable to contact parent

IN ORDER TO REPORT BACK INFORMATION BELOW THIS LINE, CONSENT MUST BE OBTAINED FROM THE STUDENT'S FAMILY.

- ☐ Team contacted, but parent declined evaluation
- ☐ Team determined no evaluation was needed
- ☐ Team evaluated and student did NOT qualify
- ☐ Team evaluated and student qualified for:
  - ☐ Developmental Delay (DD)

    Delays in following areas: *Cognition* *Communication* *Fine Motor* *Gross Motor* *Social-Emotional* *Adaptive*
  - ☐ Speech/Language Impairment (SL)

    Delays in following areas: *Language* *Fluency* *Voice* *Articulation*
  - ☐ Autism Spectrum Disorder (ASD)
  - ☐ Deaf/Hard of Hearing (DHH)
  - ☐ Emotional/Behavioral Disorders (EBD)
  - ☐ Other _____
- ☐ Student qualified and family declined services
- ☐ Student qualified and family accepted services

Other Referrals Made (Mental Health Services, Dev. Disabilities, CPS, ECFE, PH Nursing, HeadStart, etc.)

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