Referral Form

WCMCA Head Start
411 Industrial Park Blvd., Elbow Lake, MN 56531
P: (218)685-4486 F: (218)685-6747

Date:_____ Head Start Staff Referring: _____Head Start Staff Contact #:_____

Child's Name: _____ Child's DOB:_____ Gender: Female ◯ Male ◯

Parents/Guardians Name(s):_____

Parent/Guardian Address, City ZIP:_____

Phone Number: _____ Alternate Phone Number: _____ Best Day/Time to Reach Parent:_____

Agency/Program Name Head Start is Referring to:_____

Type of Referral: *(check all that apply)*

- ☐ Developmental Assessment
- ☐ Speech/Language Assessment
- ☐ Hearing /Inner-Ear Assessment
- ☐ Social Emotional/Behavioral Consultation
- ☐ Vision Assessment
- ☐ Mental Health Services-Diagnostic Assessment
- ☐ Nutrition Consultation
- ☐ Parent Request:*(describe)*

Reason for Referral: *(include screening results, attaching additional documentation as needed)*

Interventions Implemented: *(successful and unsuccessful)*

Additional Child/Family Support Services Utilized:

Comments:

Parent has been informed of the referral process and: ☐ **Accepts** (secure release) ☐ **Declines**

Note to parent(s):
Referral consent can be amended at your discretion. Head Start staff may revisit this form as new information is presented.

Parent/Guardian Signature: _____