ITSWC Referral Form

Please fill out entire form, print a copy for your records, and then fax to (913) 627-5501. Mark attention to Sonia Lopez: Infant Toddler Services. Your may also scan completed form/attached documents and email to: info.wycoinfanttoddler@gmail.com .
If you need assistance, please call ITSWC at (913) 627-5500.

Referral Source (fill out completely)

Date of Referral: ____

Name of person or agency making referral: ____________________________

Phone: ___________________ Fax/Email:_________________________

Reason for referral: ____

Are parents/caregivers aware referral is being made (Circle one): YES NO

Identifying Information:

Child's Name (Last, First, MI): ___________________________

DOB: __________ Age: __________ Male or Female (circle)

Who does child live with? (Circle)

Mother Father Foster Family Other: ____________

Parent:

Name(s): ____

Address: _______________________City/State: ______________ Zip: _______

Phone: _________________________ Cell Work Home

Language spoken: ___________________________________

Alternative Guardian:

Name(s): ____

Address: _______________________City/State: ______________ Zip: _______

Phone: _________________________ Cell Work Home

Language spoken: ___________________________________

Ethnicity: ____

Did the child have a low birth weight or substance exposure in utero? (Circle one) YES NO

If yes, fill out questions A-E:

a. Low birth weight: ________lbs __________oz
b. Hospital of birth: _______________________
c. Hospital of NICU stay: ___________________ Discharge Date: __________
d. Prenatal substance exposure: ______________________________
e. Substantiated abuse or neglect confirmed: YES NO

Automatic Eligibility Information (if applicable)

Identified diagnosis: ____

Where & when diagnosis identified: ______________________________________

Has child/parent received outside support for identified condition? YES NO

If yes, what agencies are involved: __________________________________

Please give present levels of concerns for each of the following developmental areas.
If concern is noted, please state reason and if you are referring to an outside source.

Developmental skill	Is there a concern?	Reason for concern & how you came to this conclusion? (observation, assessment, parent report, etc.)	Will you refer outside of ITSWC? (CCHD, CMH, specialty clinic, etc.)
Cognitive Development/Skill Acquisition	YES NO		
Communication/Language	YES NO		
Physical Development (Fine & Gross Motor)	YES NO		
Social-Emotional/ Behavioral	YES NO		
Self-Help/Adaptive Skills	YES NO		

Thank you for engaging in the child find process to determine eligibility for services to Infant Toddler Services. Referral source will receive information on the evaluation **only when ITSWC has obtained informed parent consent to release the information**. Please contact Debbie Lair for support or more clarification at (913) 627-5500 or info.wycoinfanttoddler@gmail.com.

Please include attached documents, screenings, and/or assessments.