

COMMUNITY REFERRAL FORM

Please attach the ASQ, ASQ:SE, M-CHAT or other screening tools and any authorization forms (if available)

REFERRING PROVIDER INFORMATION (INDIVIDUAL WHO WILL RECEIVE PROVIDER FEEDBACK)

Referral Date	Referral Site Name	Referring Provider Name		Title
Address		Unit	City	Zip Code
Phone Number () --		Fax Number () --		
Did you refer child/family to (check all that apply):				
<input type="checkbox"/> Regional Center of the East Bay (Date Submitted: _____)		<input type="checkbox"/> EPSDT Mental Health Services (Date Submitted: _____)		
<input type="checkbox"/> SELPA/School District (Date Submitted: _____)		<input type="checkbox"/> Other: _____ (Date Submitted: _____)		

CHILD'S INFORMATION

Child's Last Name	Child's First Name	DOB	Gender <input type="checkbox"/> F <input type="checkbox"/> M
Address		Unit	City
Zip Code			
Child's Health Insurance (if known):			

PARENT / CARETAKER'S INFORMATION

Parent/Caregiver Last Name	Parent/Caregiver First Name	Relationship to Child	Language(s) Spoken
Best Phone (check one) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		Other Phone (check one) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	
Email			
Parent/Caregiver Last Name	Parent/Caregiver First Name	Relationship to Child	Language(s) Spoken
Best Phone (check one) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		Other Phone (check one) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	
Email			

REASONS FOR CONCERN/REFERRAL (CHECK ALL THAT APPLY)

DEVELOPMENT	BEHAVIOR AND FAMILY	HEALTH AND GENERAL SUPPORT
<input type="checkbox"/> Age-appropriate adaptive skills	<input type="checkbox"/> Behavioral Concerns	<input type="checkbox"/> Basic Needs
<input type="checkbox"/> Cognitive/Learning	<input type="checkbox"/> High Family Stress	<input type="checkbox"/> Child Care
<input type="checkbox"/> Communication/Language Development	<input type="checkbox"/> Parent-Child Relationship	<input type="checkbox"/> Community Resources/Information
<input type="checkbox"/> Fine Motor	<input type="checkbox"/> Parent Support and Education	<input type="checkbox"/> Health/Medical
<input type="checkbox"/> General Developmental Guidance	<input type="checkbox"/> Sensory Concerns	<input type="checkbox"/> Hearing/Audiology
<input type="checkbox"/> Gross Motor	<input type="checkbox"/> Social Skills/Social Emotional	<input type="checkbox"/> Vision
<input type="checkbox"/> Other:	<input type="checkbox"/> Trauma/Adverse Childhood Experiences	

OTHER COMMENTS/NOTES/REASONS FOR REFERRING TO HELP ME GROW:

By signing this authorization, I am agreeing to this referral to Help Me Grow and I understand that Help Me Grow will contact me.

Parent/Guardian Signature: _____ Date: _____



AUTHORIZATION TO SHARE INFORMATION

Please fill out this form if you want your referring provider to receive information from Help Me Grow after we contact you.

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

BY SIGNING THIS FORM, I AM GIVING PERMISSION FOR HELP ME GROW TO SHARE INFORMATION WITH

(Referring Provider Name)

HELP ME GROW WILL SHARE ONLY THE FOLLOWING INFORMATION:

- **RESULTS OF DEVELOPMENTAL SCREENING**
- **RESOURCES AND REFERRALS THAT MY CHILD RECEIVES**
- **RESULTS OF LINKAGES TO RESOURCES AND REFERRALS**

I UNDERSTAND THAT:

- I agree to allow the Help Me Grow staff to share information about my child with my child's provider as listed above.
- I can end these services at any time by notifying the Help Me Grow phone line at the number below.
- I received a copy of this form and may request a copy at any time by writing to: Help Me Grow Yolo County, 1321 College Street, Suite E Woodland Ca. 95695.
- I may cancel any part of this authorization at any time by writing to: Help Me Grow Yolo County, 1321 College Street, Suite E Woodland Ca. 95695. The cancellation will take place when HMGYolo receives the request. HMGYolo is unable to take back any disclosures already made with my authorization, and is required by law to retain records of the care provided to me.
- Information shared under this authorization can be shared by the agency/provider who receives it. HMGYolo cannot control what the agency/provider does with this information. In some cases, California law prohibits the agency/provider receiving my health information from making further disclosures of it unless another authorization for that disclosure is obtained from me or unless that disclosure is specifically required or permitted by law. However, it is the agency's/provider's responsibility to determine its legal and other obligations regarding this information and for them to comply with those obligations.
- Photocopies and faxes of this signed authorization shall be treated as originals.

Parent/Guardian Signature: _____ Date: _____

This Authorization expires one year from date of signature. For more information call 1-844-410-4769.