Interagency Referral Form

To: **Date:**

From (Referring Agency) : **Education Service Center - Greenbush**
Cassandra Elsworth, Early Childhood Director

Re: Child's name _____ DOB _____

Parent's name _____

Mailing address _____

Physical address _____

Home Phone _____ Work Phone _____

Parent/Guardian Release

I, the Parent or Guardian of above named child, hereby authorize the above agencies to disclose information to each other. The extent or nature of information to be disclosed verbally or in writing is as follows: (indicate permission with a **yes** or **no**)

____ medical/health assessments, records, results
____ results of developmental, physical and psychological evaluations
____ recommendations for education and/or treatment planning
____ pictures
____ results of previous treatment
____ diagnostic and treatment progress
____ video and audio materials
____ other
____ all of the above

Signature of Parent or Legal Guardian _____ Date _____
Relationship to Child _____
Signature of Witness _____ Date _____

Reason for referral (check all that apply)

☐ results from a screening
screening instrument and results _____

☐ parent concern _____

☐ other _____

Contact person **(name/phone)** _____

Agency Response (to be completed by the agency referred to and returned to the agency making the referral)

Date _____
Has this child been recommended for a 0-3 evaluation? yes no
Based on the screening/evaluation, were services recommended? yes no
If yes, what services were recommended _____
If yes, were the services accepted or declined
If they were accepted, services to be received _____

Has this child been recommended for a 3-5 evaluation? yes no
Was the child identified for Special Education Services 3 to 5? yes no

Please attach a copy of the IFSP/IEP if applicable

Who will be the contact person for providing the services (name /phone) _____

Education Service Center-Greenbush, PO Box 189, Girard, KS 66743
620-724-6281 or FAX 620-724-4671