**EARLY INTERVENTION PROGRAM**

re-open

Date referral received

FOR OFFICE USE ONLY

**REFERRAL FORM**

**(Birth up to age three)**

**CHILD AND CAREGIVER INFORMATION**

Child name: Date of birth: MALE / FEMALE (circle one) Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_\_

***Parent/Caregiver contact information:***

Parent/Caregiver name:

Relationship to child:

Address: email: City: County: Zip code: Home phone: Cell: Text? Y / N

**REFERRAL SOURCE INFORMATION**

Agency: Agency contact person name: Phone: Fax:

Email:

# Concerns for possible delays in the following areas (please check all areas of

***concern)***

SPEECH/LANGUAGE ADAPTIVE/SELF-HELP

GROSS MOTOR FINE MOTOR

COGNITIVE/PROBLEM-SOLVING SOCIAL-EMOTIONAL OR BEHAVIORAL HEARING VISION

OTHER:

# After initial appt., please send the following information (check all that apply):

Status of Initial Family Contact Family Declined Services

Developmental Evaluation Results Eligibility Status

*I have spoken to the above name’s parent/caregiver and confirm that the parent/caregiver has a concern about the child's development and would like to proceed with an Early Intervention program referral.*

Print Name and Signature Date

Serving North Central Montana Counties: Blaine, Cascade, Chouteau, Glacier, Hill, Liberty, Pondera, Teton, Toole

Serving Western Montana Counties: Flathead, Granite, Lake, Lincoln, Mineral, Missoula, Ravalli, Sanders

Please return form by: Mail: Benchmark HS 1601 2nd Ave N, Ste 349, Great Falls, MT 59401

Fax: 406-403-0088 Email: MTRegion2@benchmarkhs.com

Questions or information about our program call: 406-403-0087 toll free 866-235-4700