

## REFERRAL FORM

Please complete this form to refer a child to Support for Families and/or Help Me Grow San Francisco. This form must be completed and signed. Please print clearly. Please send form to [referral@supportforfamilies.org](mailto:referral@supportforfamilies.org) or fax to (415) 282-1226.

**Child and Parent/Guardian's Information** (\*required information):

**Referral Date:** \_\_\_\_\_

*Child Name:	*Child DOB:	UCI #	Gender: M    F    X
Child Ethnicity:		*Language(s) Spoken at Home:	
*Parent/Guardian Name:	Parent/Guardian Ethnicity:	Relationship to Child:	
*Address:	City:	Zip:	
*Phone:	Email:		

**Reason(s) for Referral (Please check all that apply)**

<p>Observed/ Suspected delay or concern <b>(please share all concerns)</b></p> <p><input type="checkbox"/> Behavior   <input type="checkbox"/> Social/Emotional   <input type="checkbox"/> Speech &amp; Language   <input type="checkbox"/> Motor Development   <input type="checkbox"/> Other: _____</p> <p>Developmental Screening - Date of Screen: _____ <b>(Attach screening results)</b></p> <p>Indicate screen used: <input type="checkbox"/> ASQ-3   <input type="checkbox"/> ASQ:SE-2   <input type="checkbox"/> PEDS   <input type="checkbox"/> M-CHAT   <input type="checkbox"/> Other: _____</p> <p>Does the child have an IEP or IFSP? <input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> Do Not Know   <b>(Attach IEP/IFSP documentation)</b></p> <p>Condition/ Diagnosis (Medical Professional Use ONLY): _____ <b>(Attach assessment results)</b></p> <p>Diagnosed by: <input type="checkbox"/> Pediatrician   <input type="checkbox"/> Psychologist   <input type="checkbox"/> Neurologist   <input type="checkbox"/> Other: _____</p> <p>Other/Comments: _____</p>
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**Referring Agency Information:**

Name:	Referring Agency/ Program Information:	
Position/Title:	Phone:	Email:
Address:		
<p>Family has already been referred to:</p> <p><input type="checkbox"/> Golden Gate Regional Center (GGRC)    _____</p> <p><input type="checkbox"/> San Francisco Unified (SFUSD)    _____</p> <p><input type="checkbox"/> Beacon/ABA Service    _____</p> <p><input type="checkbox"/> California Children's Services (CCS)    _____</p> <p><input type="checkbox"/> Other: _____</p>	<p>Date Referred: _____</p>	<p>Family interested in referral for:</p> <p><input type="checkbox"/> GGRC   <input type="checkbox"/> SFUSD   <input type="checkbox"/> Beacon/ABA   <input type="checkbox"/> CCS</p> <p><input type="checkbox"/> ECE Inclusion Coaching   <input type="checkbox"/> Child Care   <input type="checkbox"/> Legal</p> <p><input type="checkbox"/> Parenting Skills   <input type="checkbox"/> Support Group(s)   <input type="checkbox"/> Housing</p> <p><input type="checkbox"/> Health Insurance   <input type="checkbox"/> Playgroup(s)   <input type="checkbox"/> Counseling</p> <p><input type="checkbox"/> Other: _____</p>

**Parent/Guardian Consent:** Please be advised we will not be able to contact you without written consent from the family.

<p><b>I give permission to Support for Families, the referring agency, and any agency(ies) indicated above to obtain and exchange pertinent information regarding my child.</b></p> <p><b>Initials I UNDERSTAND THAT:</b></p> <p>_____ The shared information will only be used to coordinate and plan resources and referrals for my child and confidentiality will be maintained.</p> <p>_____ I understand that SFCD staff member(s) will be contacting me to follow up on my concern for my child.</p> <p>_____ I may rescind my permission at any time by writing a note to the agencies/individuals. Expires: _____</p> <p>_____ A photocopy of this form is as valid as the original and I request a copy</p> <p>Parent/Guardian Signature: _____ Date: _____</p> <p>Parent/Guardian Printed Name: _____</p>	
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