EI/ECSE Referral & Referral Feedback Form – Birth to Age 5

CHILD/PARENT CONTACT INFORMATION

Child's Name: ______________________________ Date of Birth: ______/______/______

Parent/Guardian: ______________________________ Relationship to the Child: ______________________________

Home Address: ______________________________ County: ______________________________

Primary Phone: ______________________________ Other Phone: ______________________________

Primary Language: ______________________________ Interpreter Needed: Yes No

PARENT CONSENT FOR RELEASE OF INFORMATION

*Consent for release of medical information (HIPAA)**

I, ______________________________ (print name of parent or guardian), give permission for my child's health provider,________ __________________________ (print providers name), to share any and all pertinent information regarding my child, ______________________________ (print child's name), with Early Intervention/Early Childhood Special Education services.

Parent/Guardian Signature: ______________________________ **Date:** ______/______/______

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*Consent for release of educational information (FERPA)**

I, ______________________________ (print name of parent or guardian), give permission for Early Intervention/ Early Childhood Special Education services to share developmental and educational information regarding my child, ______________________________ (print child's name), with the child health provider who referred my child to ensure they are informed of status of my child.

Parent/Guardian Signature: ______________________________ **Date:** ______/______/______

*Consent is effective for a period of one year from the date of your signature on this release.

PROVIDER REASON FOR REFERRAL

Provider completed information. Please check all that apply.

□ Identified condition or diagnosis known to have a high probability of resulting in significant developmental delays (please describe): ______________________________ ________

□ Developmental risk factors (medical or psychosocial):______________________________

□ Clinician concerns but not screened Caregiver concerns but not screened Concerning screen(s): (check below)

ASQ ASQ:SE PEDS PEDS:DM M-CHAT M-CHAT Follow-up Interview Other screen:_______________

Concerns for possible delays in the following areas (please check all areas of concern):

Speech and Language Gross Motor Hearing

Adaptive/Self-Help Fine Motor Vision

Cognitive/Problem-Solving Social-Emotional/ Behavior Other: ______________________________

REFERRING PROVIDER INFORMATION

Name of provider making referral: ______________________________

Address: ______________________________

City: ______________________________ State: ______________________________ Zip: ______________________________

Office Phone: ______________________________ Office Fax: ______________________________

Please fax (or mail) our office copies of the following documents (to be reviewed by the child's health provider):

Evaluation Report Eligibility Statement Individual Family Service Plan (IFSP) Referral status/ feedback notes

EI/ECSE REFERRAL FEEDBACK

***EI/ESCE** please complete this portion and return to the referral source above.*

The child was evaluated on ______/_______/______ (date) and was found to be: **Eligible for services** **Not eligible at this time**

If non-eligible, check those that apply: Lost to follow-up Refusal of services Screened out Not eligible but to be monitored

Child was referred to:______________________________

EI/ECSE County Contact: ______________________________

* This form was developed as part of a collaboration between the Oregon Department of Education (ODE), Oregon Center for Children & Youth with Special Healthcare Needs (OCCYSHN), Oregon Public Health Division and Northwest Early Childhood Institute (NWECI) in partnership with Oregon ABCD Screening Initiative. The original referral form was developed by the American Academy of Pediatrics. Kevin Marks, MD made further modifications to improve communications between medical homes & EI/ECSE agencies.

EI/ECSE Referral & Referral Feedback Form – Birth to Age 5
CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN HEALTHCARE PROVIDERS and EARLY INTERVENTION

This consent for release of information authorizes the disclosure and/or use of your child's health information from your child's doctor to the Early Intervention/Early Childhood Special Education (EI/ECSE) program. This consent form also authorizes the disclosure of developmental and educational information from the Early Intervention/Early Childhood Special Education program to your child's doctor.

Why is this consent form important?
Your child's health care provider sees your child at well-child screening visits and for medical treatment. Sometimes your child's health care provider may see the need for more information, like evaluation or follow up by other specialists, to identify your child's special health care needs. The Early Intervention/Early Childhood Special Education (EI/ECSE) program can be a resource to help identify your child's needs. The primary goal of this consent form is to allow communication between your child's health care provider and EI/ECSE programs so these providers can work together to help your child.

Why am I asked to sign two separate consents on this form?
The first consent allows your health care provider to share information about your child with EI/ECSE. The second consent allows EI/ECSE to share information about your child with your health care provider. Your consent for the release of information allows your child's health care provider and EI/ECSE communicate with one another to ensure your child gets the care your child needs. However, as your child's parent or legal guardian you may refuse to give consent to this release of information.

What is the purpose of this consent form?
This consent form was developed to ensure compliance with all federal and state laws regarding the protection of patient information. This consent includes the sharing of information as authorized under both Health Insurance Portability and Accountability Act (HIPPA) and Family Educational Rights and Privacy Act (FERPA) guidelines. The purpose of the HIPAA consent is to provide EI/ECSE with information necessary to determine your child's eligibility for EI/ECSE services. The purpose of the FERPA consent is to ensure that your child's doctor receives information regarding the status of your child. By authorizing EI/ECSE to provide the doctor who referred your child with pertinent information the doctor remains an active participant in your child's growth and development.

How will this consent be used?
This consent form will follow your child as he/she is screened and/or evaluated at EI/ECSE. The information generated by this release will become a part of your child's educational record. EI/ECSE will protect this information as prescribed by FERPA. Information will be shared with only individuals working at or with EI/ECSE for the purpose of providing safe, appropriate and least restrictive educational settings and services.

How long is the consent good for?
This consent is effective for a period of one year from the date of your signature on the release.

What are my rights?
You have the following rights with respect to this consent:

- You may revoke this consent at anytime.
- You have the right to receive a copy of the Authorization.

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