**Family Infant Toddler (FIT) Program**
**EARLY INTERVENTION REFERRAL**

If you or a parent are concerned about the development of a child birth to age three - you can make a referral to the Family Infant Toddler (FIT) Program. The FIT program will complete a comprehensive developmental evaluation. If the child is determined eligible the family will provide early intervention services. You may contact a FIT provider directly, or, If you prefer, you may fax this form to the FIT Program's Central Fax line, and we will contact the appropriate provider for you. Thank you for your referral.

**Toll Free Fax Number: 1-866-829-8838**

## Child Contact Information

Child Name: _____ Date of Birth: _____ Gender: ❑ M ❑ F
Home Address: _____ City: _____ State: _____ Zip: _____
Parent/Guardian: _____ Primary Language: _____
Home Phone: _____ Other Phone: _____

## Reason(s) of Referral

Reason(s) for referral to early intervention (Please check all that apply):

❑ Identified condition or diagnosis (e.g. Spina bifida, Down syndrome, vision / hearing loss etc) if applicable:

_____

**OR**

Suspected developmental delay or concern (Please circle areas of concern):

❑ Motor/Physical ❑ Cognitive ❑ Social/Emotional ❑ Speech/communication ❑ Behavior / Adaptive

Other: _____

❑ At Risk (Please describe risk factors): _____

Was a developmental screening conducted (not required) ❑ Yes ❑ No

Screening Results (If applicable): _____

## Feedback Requested by the Referral Source

I would like to receive the following from the FIT Program provider agency:

❑ A copy of the Comprehensive Developmental Evaluation
❑ A copy of the Individualized Family Services Plan (IFSP) - that lists the services to be provided
❑ An invitation to participate in the IFSP
❑ Other (Please describe): _____

## Referral Source Contact Information

Person Making Referral: _____ Date of Referral: _____
Address: _____ City: _____ State: _____ Zip: _____
Office Phone: _____ Office Fax: _____
Signature: _____ Date: _____

## Release of Information Consent from Parent/Guardian

I, _____ (Print name of parent or guardian), give my permission for my pediatric health care provider, _____ (print provider's name), to share any and all pertinent information regarding my child, _____ (print child's name), with the Family Infant Toddler (FIT) Program.
Parent/Legal Guardian Signature: _____ Date: _____