Infant/Toddler HEALTH & DEVELOPMENT CONSULTATION REQUEST

DATE: _____ PROGRAM: _____ PERSON MAKING REQUEST: _____

CHILD: _____ **DOB:** _____ **Enrolled Since:** _____

Address: _____

Parent/caregiver:_____ **Relationship:** _____ **Contact #:**_____

Parent/caregiver:_____ **Relationship:** _____ **Contact #:**_____

EHS: Y N Advocate/CBFS:_____ Program Nurse: _____

FORM #401 **CONSENT** required. Is this attached? _____

REASON FOR REFERRAL (Check all that apply):

☐ Health
☐ Sensory
☐ Developmental
☐ Social-emotional/Behavioral
☐ Teacher-Child Relationship
☐ Other (Please specify):

Areas of STRENGTHS	Areas of CONCERNS
Sensory:	**Sensory:**
Developmental:	**Developmental:**
Health:	**Health (eg: any medications, prematurity, hospitalizations, diagnosis, chronic conditions, recurrent or recent illnesses):**
Social-emotional/Behavioral:	**Social-emotional/Behavioral:**
Teacher-child Relationship:	**Teacher-child Relationship:**

Summarize known family history and relevant current situation:_____

_____

_____

_____

Other individuals/services involved with this child: _____

_____

_____

*Child name:*_____

What do you think might be factors contributing to the concern? _____

_____

_____

_____

_____

When did you first notice the concern? _____

_____

_____

_____

CLASSROOM or INDIVIDUAL STRATEGIES:

That have worked (at least some times):	That haven't worked yet:

What was shared with the child's family about your concern?_____

_____

_____

_____

What was the family's response?_____

_____

_____

_____

What do you and/or your co-teachers want for support?_____

_____

_____

_____

Anything else you would like to share? _____

_____

_____

_____

Site Director notes based on observations (not required for referral to be sent):

_____

_____

_____

Please email referral to **ITHAD@reachdane.org and CC: your site director and CBFS** (if relevant). The Child and Family Programming Director will forward to the Enrollment Specialist for entry into Child Plus.