|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 45 Day | IS Initials | Process Date | UCI | Last Name | First Name | MO | Language | Co | City/Zip(SF) | HR | Date Assigned | SC Assigned |
|  |  |  |  |  |  | **0** |  |  |  |  |  |  |

**Golden Gate Regional Center – Early Start Referral Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date of Referral: | Child’s LAST Name: | | | | | | | Child’s FIRST Name: | | | | | Date of Birth:  =0m | Sex: |
| Person making referral:  Fax  Phone  Email | | | | | | | Referrer’s Agency/Organization Name: | | | | Referrer’s Phone # / Fax # / Email: | | | |
| **Attached:**   ROI (for assessment outcome check)  Developmental Screening Tool  Discharge Summary/ Medical Reports/Notes | | | | | | | | | | | | | | |
| **Check if parent(s) is aware of, and agree to, (1) this Early Start referral; (2) potential state fee ($0-200, yearly) beyond assessment and case management services. Children with Medi-Cal and low income families are exempt from fee. Details:** [**http://www.dds.ca.gov/annualfamilyprogram/**](http://www.dds.ca.gov/annualfamilyprogram/) | | | | | | | | | | | | | | |
| Parent(s) Name:  Check if CPS is currently involved | | | | | | | | | Language(s) Spoken in House:  Not Fluent in English | | | | | |
| Foster Parent’s Name: (If applicable) | | | | Contact Phone #: | | | | | | Contact Email: | | | | |
| Physical Address:  Check if mailing address is different (and list below)  Check if transient | | | | | | | | | | | | Ethnicity: | | |
| Legal Representative/ Educational Rights: | | | | | Birth Hospital: | | | | | | | Primary Care Physician/Group: | | |
| Therapist/Professionals/Agencies involved (e.g. CPS, ST, OT, PT, CCS, ABA) & Contact Person: | | | | | | | | | | | | Child’s Insurance Provider & #: | | |
| **please attach any pertinent medical or developmental report to expedite the assessment process** | | | | | | | | | | | | | | |
| Developmental Delay Please elaborate the delay(s) in detail AND indicate if having significant concern for a specific diagnosis (e.g. autism): | | | | | | | | | | | | | | |
| Cognitive | |  | | | | | | | | | | | | |
| Physical/ Motor | |  | | | | | | | | | | | | |
| Vision/ Hearing | |  | | | | | | | | | | | | |
| Communication | |  | | | | | | | | | | | | |
| Social/ Emotional | |  | | | | | | | | | | | | |
| Adaptive/ Self-Help | |  | | | | | | | | | | | | |
| Established Risk (Specific Diagnosis): | | | | | |  | | | | | | | | |
| High Risk – A) 2 or more items (attach report):  Prematurity of less than 32 weeks gestation and/or birth weight of less than 1500 grams  Assisted ventilation of more than 48 hrs during first 28 days  Small for gestational age  Asphyxia neonatorum - with 5 min. Apgar score 0-5  Neonatal seizures or nonfebrile seizures  Central nervous system lesion or abnormality  Central nervous system infection  Multiple congenital anomalies or genetic disorders | | | | | | | | Clinically significant failure to thrive  Persistent hypotonia or hypertonia  Prenatal exposure to known teratogens  Prenatal substance exposure, positive infant neonatal toxicology screen or symptomatic neonatal toxicity or withdrawal.  Severe and persistent metabolic abnormality  Biomedical insult including, but not limited to, injury, accident or illness which may seriously affect development outcome | | | | | | |
| High Risk – B)  Infant or toddler is a child of a person with developmental disability and requires intervention services | | | | | | | | | | | | | | |
| Additional Comments/ Other Social Factors: | | |  | | | | | | | | | | | |

**To check outcome of assessment via Email –** only if ROI is attached – [intake@ggrc.org](mailto:intake@ggrc.org?subject=Early%20Start%20Outcome%20of%20Assessment%20Check) with subject “ES – Outcome Check – [referral date]”

**To refer via Email –** Attach this referral form and related reports to [intake@ggrc.org](mailto:intake@ggrc.org?subject=Early%20Start%20Referral) – with subject “New Early Start Referral”

**To refer via Fax –** Fax#: (888) 339-3306