|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 with subject “ES – Outcome Check – [referral date]”

**To refer via Email –** Attach this referral form and related reports to intake@ggrc.org – with subject “New Early Start Referral”

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