Justice Resource Institute

Early Childhood Training & Consultation Program

REFERRAL FORM

Referred By: ___________________________

Childcare Program/Provider: ____

Program Address: ____ Zip Code: ______________

Program Contact Phone #: ________________________________ EEC Program #: _________________

Director's Name & Email: ____ Fax #: ___________________

Classroom Teacher(s) ____

Please circle the type of referral that you are sending in:

Type of Referral: Child / Classroom / Program

Identified Child & Parent/Guardian sections must be completed when sending in an Individual Child Referral.

Identified Child:

Name: ____ Date of Birth: ________________________

Gender: Male_______ Female_______ Ethnicity: ____________________________

Primary Language: __________________ Religion____________________________

Home Address: ____Zip Code: __________

Family Construct: Mother________ Father________# of Siblings________ Other__________

Date of Enrollment in your Program: ____________________________

Does the child fill a contract/voucher slot? ______________

Parent/Guardian:

Name: _____________________________________ Relationship to Child: __________________

Contact #: ___________________________________ Primary Language: ____________________

Parent/Guardian E-Mail Address: ____

Ethnicity: ____________________________________ Religion: _____________________________

FOR OFFICE USE ONLY: Date Completed Referral Received ____________ Notes:

Concerns:

☐ Behavioral ☐ Developmental ☐ Speech

☐ Other: ______________________

If behavioral, please check all that apply:

☐	Aggression	☐	Poor social skills
☐	Self-injurious behavior	☐	Fearful, anxious, withdrawn
☐	Temper tantrums	☐	Overactive, impulsive
☐	Sexualized behavior	☐	Non-compliant, oppositional
☐	Destruction of property	☐	Inattentive, unable to focus

Is the child at risk of suspension/expulsion from the program?

☐ Yes ☐ No

Other services child has received/is receiving:

☐	Early Intervention	☐	Department of Children & Families
☐	Individual/play therapy	☐	504 Plan
☐	Family therapy	☐	Special Education Evaluation
☐	IEP/IFSP	☐	Medication______________________

Has the parent/guardian signed the Consent to Receive Services form?

☐ Yes ☐ No

FOR OFFICE USE ONLY:
Date Completed Consent Received: ______________

Referrals will not be processed without a signed consent form from the parent/guardian.

Additional Comments:

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We will work in partnership with Justice Resource Institute's Early Childhood Training and Consultation Program on service year expectations and provide access to the classroom to enable consultants to observe and assess the needs of the referred child; develop a written behavioral observation plan; consult to classroom staff; meet with parents; and model applicable interventions to address the needs of the child.

______________________________ ______________________

Program Director **Date**

______________________________ ______________________

ECTC Consultant, JRI **Date**

Please E-mail completed forms to: LSMALL@jri.org and SGAY@jri.org
Or fax completed forms to: 508-822-2601