

Early Childhood Training & Consultation Program

REFERRAL FORM

Referred By: _____

Childcare Program/Provider Name: _____

Program Address & City: _____ Zip Code: _____

Program's Phone Number: _____ EEC Program #: _____

Director's Name & Email: _____ Fax #: _____

Classroom Name: _____ Teacher(s): _____

Please check 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 & Consent Received: _____

Notes: _____

Please complete this section for all referrals

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| ☐ Self-injurious behavior | ☐ Fearful, ☐ Anxious, ☐ Withdrawn |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 ☐ Other: _____ |

Please complete this section for individual child referrals

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 _____ |

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

Has the parent/guardian signed the Consent to Receive Services form? ☐ Yes ☐ No ☐ N/A

Additional Comments: (If needed, please complete this section for all referrals)

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 Name (Please print) & Signature

Date

ECTC Consultant, JRI Name (Please print) & Signature

Date

Please E-mail completed forms to: LSMALL@jri.org and SGAY@jri.org
Or fax completed forms to: 508-822-8660

