Early Intervention Colorado Referral and Release Form

For Infants and Toddlers- Birth through Two Years of Age Who May Need Early Intervention Services

Referral Information

Community Centered Board: **Imagine!** ______ **Fax:** 303-665-2648 ______

Child's Name: ______ ☐ Boy ☐ Girl DOB: ______

Parent(s)/Legal Guardian: ______ Phone: ______

Family's Address: ______ County: ______

Family's E-mail: ______ Alt Phone: ______

Primary Language Spoken by Parent(s)/Legal Guardian/Foster Parents: ☐ English ☐ Spanish ☐ Other ______

Primary Care Physician (PCP): ______ PCP E-mail: ______ Phone: ______

DHS REFERRALS ONLY CAPTA? ☐ YES ☐ NO

Legal Status of child:
☐ Biological parent custody, rights intact ☐ Foster/Kinship care, biological rights intact ☐ Foster/Kinship care, parent rights terminated

Foster/Kinship Parent(s) (if applicable): ______ **Phone:** ______

Foster/Kinship Parent(s) Address: ______ County: ______

How long has child resided at this residence? ______ Surrogate/ Advocate/ Guardian ad Litem? ☐ YES ☐ NO

If yes, Name: ______ Phone: ______

Assigned DSS Caseworker: ______ Phone: ______

E-mail: ______ Case open? ☐ YES ☐ NO

Guardian ad Litem (GAL) Name: ______ Phone: ______

GAL E-mail: ______ Educational Decision-making authority? ☐ YES ☐ NO

Referring Practice/Agency: ______ Referring Person: ______

Referring Person Phone: ______ Referring Person Fax: ______

Referring Person E-mail: ______

Are you a Qualified Health Professional? *(See referral source guide for list)* ☐ YES ☐ NO If yes, Discipline: ______

Person to send referral status update to; if different: ______ Fax, if different: ______

Has a developmental screening been completed for this child? ☐ YES ☐ NO **If *yes, send the screening results with the referral.***

Please check and complete one of the following boxes (**A** or **B**):

A. ☐ **This child has been diagnosed with the following physical or mental condition(s) known to have a high probability of resulting in significant delays in development (*even if no delays are apparent at this time*):**

______

(See the Established Condition Database located at www.eicolorado.org for a complete list of qualifying diagnoses.)

B. ☐ **There are concerns for possible delays in development in the following area(s):** ______

Signed:______ (referring person) Date of Referral: ______

Authorization to Release Information (optional)

I authorize the Community Centered Board Early Intervention Colorado Program to share the following information with the referring practice/agency listed above.

- ☐ Eligibility outcome information (eligible/not eligible)
- ☐ Evaluation/Assessment results (range of delay for each developmental domain)
- ☐ Ongoing Early Intervention Services included on the Individualized Family Service Plan for the purpose of care coordination.

I understand that I may withdraw this consent by written request to the Community Centered Board Early Intervention Colorado Program. If consent is revoked it does not apply to any actions that occurred before consent was revoked.

I certify that this authorization to release this information has been given freely and voluntarily. Information collected related to early intervention services may not be shared unless the person who consented to sharing this information specifically consents to it and or the sharing this information is allowed by law. I understand I have a right to inspect and copy the information to be disclosed.

Signed:______ Date: ______
(*child's parent or legal guardian*)

*Authorization is effective for a period of 12 months from this date

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B. ☐ There are concerns for possible delays in development in the following area(s): ______

Signed:______ (referring person) Date of Referral: ______

Autorización para divulgar información (opcional)

Yo autorizo a la Mesa Comunitaria del Programa de Intervención Temprana de Colorado para compartir la siguiente información con la práctica / agencia mencionada anteriormente que hace la referencia.

- ☐ Información sobre los resultados de elegibilidad (califica / no califica)
- ☐ Resultados de la evaluación / revisión (margen de demora para cada área del desarrollo)
- ☐ Servicios continuos de Intervención Temprana incluidos en el Plan Individualizado de Servicios Familiares, con el propósito de la coordinación de atención.

Entiendo que puedo retirar esta autorización por medio de una petición por escrito dirigida a la Mesa Comunitaria del Programa de Intervención Temprana de Colorado. Si retiro la autorización, la revocación no aplica a las acciones que ocurrieron antes de que la autorización haya sido retirada.

Yo certifico que esta autorización para divulgar esta información se ha dado de forma libre y voluntaria. La información recopilada relacionada con los servicios de intervención temprana no puede ser compartida a menos que la persona que consintió en compartir esta información consienta específicamente que se comparta y/o que compartir esta información esté permitido por la ley. Entiendo que tengo el derecho a inspeccionar y copiar la información a ser divulgada.

Firmada:______ Fecha:______

Padre, madre o tutor legal del niño(a)

* La autorización es vigente durante un período de 12 meses a partir de esta fecha

Para más información llame al 1-888-777-4041 o visite www.eicolorado.org