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| https://lh6.googleusercontent.com/UKR0TlROvHy3Whc95DvC5qVeR6yCh9hY0BeJXLuVQKqpEshSlpnuPxDJjcaLVV9wu1Yo225ZKVF71SqZbc1cXke9w6FlGTPy4rii4EfATF1nT0V6K7k-o0otVln2UA  **Procedures for Referral to Early Intervention**  **Birth to Three Programs**  **Keep this procedure checklist in the child’s disability file. This form is not sent to Early Intervention** – it is used by staff to assist in completing the process. All steps of the referral process must also be documented in COPA under child’s case notes. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Child’s Name:** | | |  | | | | | | | | | | | | | | | | Male  Female | | | | | | | | | | | **Date of Birth:** | | | | | | | **/**     **/** | |
|  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | (MM/DD/YYYY) | |
| **Primary Language:** | | | | | | |  | | | | | | | | | | | | | **Home Language:** | | | | | | | | |  | | | | | | | | | |
| **Agency/Site Name:** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Disabilities Contact Name/Title:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Classroom Teacher/FCCH Provider/Home Visitor:** | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| **Check each task as it is completed**  **Screening of Child** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | **Ages and Stages Questionnaire – Third Edition (ASQ-3) Results** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | **Initial Screening Date:** **/****/** | | | | | | | | | | | | | | | | | | | | **Rescreen Date:      /     /** (if necessary) | | | | | | | | | | | | | | | | |
|  | | **Area** | | **Refer** | | **RS** | | | | **OK** | | | **Comments** | | | | | | | | | **Area** | | | | | | **Refer** | | | **RS** | **OK** | | | **Comments** | | | |
|  | | Communication | |  | |  | | | |  | | |  | | | | | | | | | Communication | | | | | |  | | |  |  | | |  | | | |
|  | | Gross Motor | |  | |  | | | |  | | |  | | | | | | | | | Gross Motor | | | | | |  | | |  |  | | |  | | | |
|  | | Fine Motor | |  | |  | | | |  | | |  | | | | | | | | | Fine Motor | | | | | |  | | |  |  | | |  | | | |
|  | | Problem Solving | |  | |  | | | |  | | |  | | | | | | | | | Problem Solving | | | | | |  | | |  |  | | |  | | | |
|  | | Personal-Social | |  | |  | | | |  | | |  | | | | | | | | | Personal-Social | | | | | |  | | |  |  | | |  | | | |
|  | | **Ages and Stages Questionnaire: Social-Emotional, Second Edition (ASQ:SE-2) Results** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | **Date** | | | | | | **Refer** | **Monitor** | | | **OK** | | | | | | **Comments** | | | | | | | | | | | | | | | |
|  | | Parent-Completed | | | | |  | | | | | |  |  | | |  | | | | | |  | | | | | | | | | | | | | | | |
|  | | Teacher-Completed | | | | |  | | | | | |  |  | | |  | | | | | |  | | | | | | | | | | | | | | | |
| **Within 5 Days of Screening/Notice of Concern** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date Teacher/Provider/Home Visitor informed Disabilities Services Coordinator (DSC) of need for referral**      /     / | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Internal Staffing** *The Disabilities Coordinator meets with the classroom staff/provider/home visitor and mental health consultant, if necessary, to review child’s screening results and performance.* **Date:**      /     / | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | The team is concerned about this child’s development in the following areas: | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | Parent concerns that have been shared with staff: | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | Health history (including information from hearing/vision): | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| **Within 15 Days of Screening/Notice of Concern** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Screening Review Team (SRT) Meeting Date:**      /     /  The SRT team should consist of the parent, classroom staff/provider/home visitor, DSC (or designee) and mental health consultant (when appropriate) to discuss: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * Purpose of the developmental screening and results * Observations/examples from the classroom/FCCH/home visits * The Early Intervention referral process * Parents’ rights and responsibilities (give summary found on the CSD website under Disabilities) * Inform the parent that if invited, the Disabilities Coordinator would attend the Individualized Family Service Plan (IFSP) conference with the parent. | | | | | | | | | | | | | | | | | | | | | * The parent may request services to be provided in the home or at the EHS/CC program. * It is the parent’s decision whether or not to have the child evaluated. * The parent will be the primary person responsible for scheduling the evaluation. Parents may request staff to assist in the process. * If the parent chooses not to have the child evaluated by EI/CFC at the time of the SRT meeting, they may request an evaluation at a later date. | | | | | | | | | | | | | | | | | |
| Does the parent choose to have the child evaluated by EI/CFC?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **If no,** parent signs here to document declining: **Parent Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Notes from SRT Meeting:** Area/s Of Concern *(check all that apply and add comments)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Motor/Physical | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cognitive | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Social/Emotional | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Speech/Language/Communication | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Behavior | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Vision | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hearing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Adaptive/Self-Help Skills | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Determine EI/CFC Program by Family’s Zip Code** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CFC #8** Easter Seals Society of Metropolitan Chicago 3101 W. 95th St., Evergreen Park | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | P 773-233-1799 | | | | | F 773-233-2011 | |
| **CFC #9** Hektoen Institute Cook Co. Children’s Hospital 5422 West Roosevelt Road | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | P 773-830-5200 | | | | | F 773-830-5201 | |
| **CFC #10** LaRabida Children’s Hospital 1525 East 55th Street, Suite 203 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | P 773-324-7434 | | | | | F 773-324-7469 | |
| **CFC #11** Rush University Medical Center 945 West George Street, Suite 300 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | P 312-942-7800 | | | | | F 312-942-7811 | |
| **Other CFC:** # | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | P: | | | | | F: | |
| Online Early Intervention CFC locator: [www.dhs.state.il.us/page.aspx?module=12](http://www.dhs.state.il.us/page.aspx?module=12) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Contact CFC.** If the parent agrees to have his/her child evaluated, the referral form may be faxed or mailed to the appropriate CFC. In addition to sending the referral form, the Disabilities Coordinator may assist the parent in calling the CFC at the time of the meeting to make the referral over the phone. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CFC Contact Name/Title:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | **Date contacted:** | | | | | | | /     / | | | | |
| **Send** DFSS Early Intervention Referral and Authorization to Release Information to CFC  *(additional information may be submitted, but is not required)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Check on status of evaluation.** Network or Disabilities Coordinator will check with parents to see if CFC has contacted them. If parents have not been contacted within 10 days of the Referral, the Disabilities Coordinator will assist parent in contacting the CFC.  **Date of Status Check:**      /     /      **45 Day Deadline for Evaluation:**      /     / | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Service Coordinator:** | | | | | | | | |  | | | | | | | | | | | | | | | | **Direct Phone Number:** | | | | | | | | | | | (     )      - | | |
| **Individualized Family Service Plan (IFSP) Meeting.** Parents will be sent a notification of IFSP meeting prior to the meeting date. Parents may invite EHS/FCCH Network Coordinator, Disabilities Coordinator, classroom staff, or provider to attend this meeting.  **Date of IFSP Meeting:**      /     /  **Is child eligible for Early Intervention Services?**  Yes  No  **Obtain copy of IFSP** for child’s disability file to document on COPA and to assist in individualizing for child.  **Monitor Services.** Network or Disabilities Coordinator will monitor services provided by Early Intervention (EI) Professionals on a regular basis. Monitoring includes:   * Assuring that services are being delivered in the matter and at the location described in the IFSP. * If the family chooses to have the EHS/FCCH staff participate in the IFSP, assist EI staff in identifying EHS/FCCH personnel with whom they will work most closely to meet child’s IFSP goals. * Supporting EHS/FCCH Staff in understanding the child’s disability and the effect of that disability on daily functioning.   **Transition Services:** Collaborate with transition coordinator to assure smooth transitioning to Special Education Services or out of Early Intervention Services. Date transition should begin (when child turns 2 years, 6 months):      /     / | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

