

Anyone may refer a child between the ages of 2 years 8 months and 5 years 10 months for a screening. A special education evaluation can only begin after a parent/guardian has provided written consent.

Today's Date: *
mm/dd/yyyy

CHILD INFORMATION (*Indicates a required field.)

A

Child First Name *

Child Last Name *

Date of Birth *

Gender *

- ☐ Female
☐ Male
☐ Non-binary

Race/Ethnicity (Check any that apply.) *

- ☐ Asian ☐ American Indian/Alaskan Native
☐ Black ☐ Native Hawaiian/Other Pacific Islander
☐ White

Hispanic/Latino *

- ☐ Yes
☐ No

School or Child Care Type *

- ☐ Private or Religious School ☐ Public Charter School ☐ DC Public School ☐ Unknown
☐ Child Development Center ☐ Not Enrolled

School or Child Care Name *

Parent/Guardian Name *

Relationship to Child

Primary Phone *

Street Address *

Other Phone

City/State/Zip *

Email *

Parent/Guardian Primary Language *

Child Primary Language *

Reason for Referral *

Is the referred child currently receiving or have they ever received any of the following (Check any that apply.) *

- ☐ Evaluation (i.e: developmental, speech, OT/PT, etc.) ☐ IEP
☐ Hearing and Vision Screening ☐ IFSP
☐ Developmental Screening (i.e: ASQ, PEDS, M-CHAT, etc.) ☐ Services Plan (ISP)

REFERRER INFORMATION (Only complete if you are not the parent.)

B

Referrer Organization

Referrer Name

Referrer Email

Referrer Phone

Organization Phone

PEDIATRICIAN INFORMATION (Please complete if known.)

C

Pediatrician Name

Pediatrician Email

Pediatrician Phone

SOCIAL WORKER INFORMATION (Please complete if known.)

D

☐ This child is involved with Child & Family Services Agency (CFSA)

Social Worker Name

Social Worker Email

Social Worker Phone

HOW DID YOU HEAR ABOUT EARLY STAGES?*

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Google Ad | <input type="checkbox"/> Print Publication Advertisement | <input type="checkbox"/> School | <input type="checkbox"/> Early Stages Employee |
| <input type="checkbox"/> LinkedIn | <input type="checkbox"/> Early Stages Workshop | <input type="checkbox"/> Child Care Center | <input type="checkbox"/> Other DCPS Employee |
| <input type="checkbox"/> Bus or Bus Shelter Advertisement | <input type="checkbox"/> Early Stages Developmental Screening Event | <input type="checkbox"/> Social Worker | <input type="checkbox"/> Friend or Family |
| <input type="checkbox"/> Online Publication Advertisement | | <input type="checkbox"/> Pediatrician or Doctor | <input type="checkbox"/> Other |

Please email this completed form to referral@earlystagesdc.org (preferred) or fax it to **(202) 654-6079**.

(202) 698-8037 | info@earlystagesdc.org | www.earlystagesdc.org