DISTRICT OF COLUMBIA PUBLIC SCHOOLS

EARLY STAGES REFERRAL FORM

EARLY STAGES

Today's Date *(mm/dd/yyyy):*

Child Name: Date of Birth:

Sex: ☐ Female ☐ Male ☐ Non-binary

Race/Ethnicity	Check any that apply: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Other Pacific Islander		
Hispanic/Latino	Check one: ☐ Yes ☐ No		
School or Child Care Type	Check any that apply: ☐ Private ☐ Religious ☐ Charter ☐ Child Care ☐ Head Start Program ☐ DC Public Schools ☐ Not Enrolled		
School or Child Care Name			
Parent/Guardian Name		Relationship to Child	
Street Address		Home Phone	
City/State/Zip		Other phone	
Parent/Guardian Primary Language		Child Primary Language	
Parent/Guardian Email			
Reason for Referral			
Referrer information (please complete if you are not the parent of the child being referred).			
Referrer Organization			
Referrer Name		Referrer Phone	
Referrer Email		Organization Phone	
Additional information (please complete if known).			
Pediatrician Name			
Pediatrician Email		Pediatrician Phone	
Social Worker Name		☐ This child is involved with Child & Family Services Agency (CFSA)	
Social Worker Email		Social Worker Phone	

Parent/Guardian Review (check all that apply):

☐ I have reviewed this referral. I understand this referral begins a process that will determine my child's eligibility for special education or equitable services. I understand I can stop this process at any time.

☐ I give consent for DCPS to share the results of my child's screening and evaluation with the person making this referral.

Sign Here

Parent/Guardian Signature:

Date:

Please fax this form to ***202.654.6079*** or email it to ***referral@earlystagesdc.org***

For more information or to refer a child, please call ***202.698.8037*** or visit our website at ***www.earlystagesdc.org.***