

STRONG START

Referral Form

CHILD IDENTIFICATION INFORMATION	
Child's Legal Name [Last, First, Middle (Optional – nickname)] Medrano, Ronald	Date of Birth 05-30-2013
Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undetermined	Ethnicity/Race: Hispanic
Insurance Name Amerihealth Insurance	Insurance Number 70688888
Parent(s)/Legal Guardian Raquel Medrano	Telephone/Email 202-727-3665/raquel.medrano@dc.gov
Parent(s)/Legal Guardian Address 810 First Street, NW, WDC 20002	Ward 6
Primary Language Spoken by Parent(s)/Legal Guardian <input checked="" type="checkbox"/> English <input checked="" type="checkbox"/> Spanish <input type="checkbox"/> Other _____	
Foster Parent(s) (if applicable)	Telephone
Foster Parent(s) Address (if applicable)	County/Ward
How long has child resided at residence?	Surrogate/Advocate/Guardian <i>ad Litem</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No
If <i>ad Litem</i> is yes, name	Telephone
Assigned CFSA Caseworker	Telephone

REFERRAL INFORMATION	
Name of Referring Person Dr. Mary Jane Jones	Agency/Practice CNMC
Phone 202-476-9999	Fax 202-476-8888
Are you a Qualified Health Professional? <input checked="" type="checkbox"/> Yes Discipline _____ <input type="checkbox"/> No	Has a developmental screening been completed? <input checked="" type="checkbox"/> Yes Tools used <u>ASQ.3</u> <input type="checkbox"/> No

Please check and complete one of the following boxes:

- This child has a current screening/evaluation demonstrating need or is currently receiving services for a diagnosed condition.
Describe: _____
- This child has been diagnosed with a 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).
Describe: _____
- There are concerns for possible delays in development in the following areas: Developmental delay especially Communication delay.

Signature: Dr. Mary Jane Jones Date: 03-31-2015

(Referring person)



Office of the State Superintendent of Education • Strong Start
 1371 Harvard Street, Washington, DC 20009
 Main: 202.727.3665 • Fax: 202.724.7230 • Email: osse.dceip@dc.gov • www.strongstartdc.com



STRONG START

PART C EVALUATION CONSENT TO RELEASE INFORMATION

It has been explained to me that because of my child's premature birth, birth complications, and/or developmental concerns, my child and family may be eligible for special services designed to assist my child in achieving his or her developmental milestones.

I hereby authorize _____ CNMC _____ to release the following information to **Strong Start**
(Referring source)
for the purpose of establishing my child's eligibility for early intervention services.

Check all that apply:

- | | | |
|--|---|--|
| <input checked="" type="checkbox"/> Referral Information | <input type="checkbox"/> Physical Therapy Evaluations | <input type="checkbox"/> Developmental Screening Results |
| <input type="checkbox"/> Admission Summary | <input type="checkbox"/> Occupational Therapy Evaluations | <input type="checkbox"/> Hearing Screen/Test Results |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Speech and Language Evaluations | <input type="checkbox"/> Vision Screen/Test Results |
| <input checked="" type="checkbox"/> Other <u>ASQ screening</u> | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

Please **read and then initial all boxes** to indicate that you understand your rights before signing. If you have any questions about your rights, please call **Strong Start** at (202) 727-3665.

RM	I understand that signing this authorization is not a condition of receiving future medical treatment or early intervention services.
RM	I understand that I may revoke (i.e., cancel) this authorization at any time by notifying Strong Start in writing, and that any information shared prior to revoking this authorization will not be affected by a revocation.
RM	I understand that before any specific services for my child are provided, I also have a right to authorize or decline those services.
RM	I understand that feedback regarding this referral, including developmental and educational information about my child, may be provided to the referring professional in order to facilitate appropriate coordination of services.
RM	I understand that if my child is Medicaid eligible and covered under EPSDT (early periodic screening diagnosis and treatment), this referral will be shared with my Medicaid Managed Care Case Manager / Service Coordinator.
RM	I understand that once released, my information may be disclosed and may no longer be protected under the Health Insurance Portability and Accountability Act (HIPAA), but will not be re-disclosed by the DC Early Intervention Program in accordance with the Family Educational Rights and Privacy Act (FERPA). For more information, see 45 CFR (Code of Federal Regulations) 164.508 for HIPAA and 34 CFR Part 99 for FERPA.
RM	I understand that this consent will expire in one (1) year and that a new consent form will need to be completed should my child continue to be eligible for Strong Start .

Signature: _____ Requel Medrano _____ Date: _____ 03-31-2015 _____
(Parent/legal guardian)

RETURN REFERRAL TO:

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INSTRUCTIONS

STEP 1 – ENTER CHILD IDENTIFICATION INFORMATION

ROW 1	ENTER CHILD'S LAST NAME, FIRST NAME, MIDDLE NAME, AND DATE OF BIRTH (DOB)
ROW 2	ENTER CHILD'S GENDER, ETHNICITY, INSURANCE PROVIDER, AND INSURANCE NUMBER (MEMBER ID)
ROW 3	ENTER GUARDIAN'S NAME AND TELEPHONE NUMBER
ROW 4	ENTER GUARDIAN'S ADDRESS AND WARD
ROW 5	CHECK THE CHILD'S PRIMARY LANGUAGE <i>IF OTHER INDICATE WHAT LANGUAGE</i>
ROWS 6-10	COMPLETE IF CFSA/COURTS ARE INVOLVED WITH CHILD Ad Litem = ATTORNEY ASSIGNED BY THE COURTS

STEP 2 – ENTER REFERRAL INFORMATION

ROW 1	PRINT FIRST AND LAST NAME OF REFERRING PERSON, ENTER REFERRING AGENCY/PRACTICE
ROW 2	ENTER YOUR CONTACT NUMBER AND EXTENSION IF APPLICABLE, AND FAX NUMBER
ROW 3	ARE YOU A QUALIFIED HEALTH PROFESSIONAL? IF YES, CHECK YES AND WRITE IN YOUR DISCIPLINE IF NO, CHECK NO
	HAS THE CHILD HAD A DEVELOPMENTAL SCREENING? IF YES, CHECK YES AND LIST TOOLS USED AND ATTACH SCREENING DOCUMENT IF NO, CHECK NO
ROW 4	CHECK AND COMPLETE THE APPLICABLE OPTIONS. SIGN YOUR NAME AND DATE THIS REFERRAL WITH TODAY'S DATE.

PAGE 2 – CONSENT TO RELEASE INFORMATION

****THIS PAGE SHOULD BE COMPLETED BY THE PARENT PRIOR TO REFERRAL****

- Parent will authorize you as the referral source to release any of the checked listed documents to: DC Part C **Strong Start**. *Please attach all checked.*
- Parent will initial each box stating he/she understands the statement of rights listed.
- Parent/guardian will sign and date. Witness (referral source) will sign and date.
- Parent should be issued a copy of the referral by the referral source.

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