eli early learning institute

REFERRAL FORM: The Consultation Project:

Please fill out as completely as possible.

Program/ Provider Information

Program Name:	**Today's Date**:	**Case #** *Office Use*	
Phone: **Best Time to Call?** **Address:** **Email:** **Fax:**			
Person Making Referral:			
Your title or relationship to the child (Check One):			
Director ☐ Teacher ☐ Family Childcare Provider ☐ Parent ☐ Other ☐			
Primary teacher/ provider name (If different than the person making the referral):			
Child's classroom/ group:	**Type of Program** (check one):		
	LCCC *center* ☐ FCC *Family childcare* ☐ Other ☐		
Child's Schedule:			

Child/ Family Information

Child's Name:		**Birth Date**:	
Home Language:	**Gender**:	**Ethnicity**:	
Parent/Guardian Name(s):		**Phone Number(s)**:	

Reason for Referral

Tell us about your concerns? **What would you like help with**?

Is this child at risk of disenrollment?	Yes ☐ No ☐	**Does this child have special needs (an IEP, IFSP, receiving Early Start or school district services?)**	Yes ☐ No ☐		
How much stress is this child's behavior/needs putting on your program?	Scale 1 – 5: (1=low,5=high)				
Are there any concerns about alcohol or drug use in the family?	Yes ☐	No ☐			
Have you sought other services/ help for this child/ family? Where? What?					
Have you used The Consultation Project before? How did you hear about the project?					

Office Use Only: Targeted School Zone?	Program	Yes ☐	No ☐	Family	Yes ☐	No ☐					
Teacher/ Provider Demo:	Language:	Gender:	Ethnicity:	Birthdate:							
Date Consent Received:		Agency assigned:		Consultant							
Intake Start		Intake End		Hours:							
Intervention Start		Intervention End		Hours:							