



STRONG START

Referral Form

CHILD IDENTIFICATION INFORMATION	
Child's Legal Name [Last, First, Middle (Optional – nickname)] Santos, Ronald	Date of Birth 01-03-2016
Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undetermined	Ethnicity/Race: Hispanic
Insurance Name Amerihealth DC Medicaid	Insurance Number 70888888
Parent(s)/Legal Guardián Raquel Medrano and Anthony Santos	Telephone/Email 202-727-3665/raquel.medrano@dc.gov
Parent(s)/Legal Guardian Address 810 First Street, NE, 5th Floor, Washington, DC 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 Children's National Medical Center (MLK)
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 ASQ screening <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 concerns, mostly communication delays**

Signature: Dr. Mary Jane Jones Date: January 06, 2017
(Referring person)



Office of the State Superintendent of Education • Strong Start
1371 Harvard Street, NW 1st Floor, Washington, DC 20009
Main: 202.727.3665 • Fax: 202.724.7230 • Email: osse.dceip@dc.gov

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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.

RETURN REFERRAL TO:

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