Help Me Grow Vermont — Universal Referral Form

The parent/guardian must be aware of this referral before *HMG* VT will contact them. You are required to obtain permission from the caregiver before requesting a referral.

Child Information

Child Name (First and Last):

_____

Child DOB (or due date): _____Gender: _____

Parent/Guardian Name (First and Last):

_____

Relationship:_____

Address:_____

_____

Phone:_____ Email:_____

Child's Race:

❑ American Indian or Alaskan Native ❑ Asian
❑ Native Hawaiian/Other Pacific Islander ❑ White
❑ Black/African American ❑ Don't Know
❑ More than one race ❑ Other: _____
❑ Declined to answer

Child Ethnicity: Hispanic/Latino ❑ Yes ❑ No

Language Spoken at Home: _____

Best Time to Contact Parent/Guardian: ❑ Morning (9am-12pm) ❑ Afternoon (12pm-4pm) ❑ Evening (4pm-6pm)

Referring Provider Information

Person/Agency/Practice requesting referral:

First and Last Name: _____

Org.(if applicable):_____

Relationship to child: ❑ Parent ❑ Legal Guardian
❑ Other Relative (type) _____
❑ Childcare provider/ Early Childhood Educator
❑ Health Care provider ❑ Mental Health Provider
❑ School District Personnel ❑ Social Service Agency
❑ DCF Family Support/Child Welfare
❑ Other_____

Phone: _____

Fax: _____

Email: _____

Mailing Address: _____

Reason for Referral Would like help connecting to: Today's Date: _____

❑ community resources and/or basic needs	❑ tools for caregivers to track developmental milestones
❑ parent support/education/skills classes	❑ specialized services such as Children's Integrated Services (CIS)
❑ area playgroups and extracurricular activities	❑ information on pregnancy, child development and parenting
❑ child care, preschool, or Head Start program	❑ other: _____

Has a developmental screening tool like the ASQ-3 been completed? ❑ Yes ❑ No

If you are an early childhood special educator, early intervention provider, or other early childhood professional please answer the following:

Has the child received a comprehensive (five domain) developmental assessment? ❑ Yes ❑ No

Has a referral to Children's Integrated Services been made? ❑ Yes ❑ No

Notes:

By signing below, the requestor certifies that the parent/guardian has given permission for information on this form to be shared between referring entity and *HMG* VT. I am the parent/guardian ❑ Yes ❑ No

_____ _____

Signature Date

Please fax this form to 802-861-2544.

Questions? Dial 2-1-1 x6 to reach a *Help Me Grow* Child Development Specialist.

www.helpmegrowvt.org / info@helpmegrowvt.org