SUPPORT FOR FAMILIES OF CHILDREN WITH DISABILITIES

Help Me Grow San Francisco

REFERRAL FORM

Please complete this form to refer a child to Support for Families and/or Help Me Grow San Francisco. This form must be completed and signed. Please print clearly. Please send form to referral@supportforfamilies.org or fax to (415) 282-1226.

Child and Parent/Guardian's Information (*required information): Referral Date: _____

*Child Name:	*Child DOB:	UCI #	Gender: M ☐ F ☐ X ☐
Child Ethnicity:	*Language(s) Spoken at Home:		
*Parent/Guardian Name:	Parent/Guardian Ethnicity:	Relationship to Child:	
*Address:	City:	Zip:	
*Phone:	Email:		

Reason(s) for Referral (Please check all that apply)

Observed/ Suspected delay or concern **(please share all concerns)**
☐ Behavior ☐ Social/Emotional ☐ Speech & Language ☐ Motor Development ☐ Other: _____

Developmental Screening - Date of Screen: _____ **(Attach screening results)**
Indicate screen used: ☐ ASQ-3 ☐ ASQ:SE-2 ☐ PEDS ☐ M-CHAT ☐ Other: _____

Does the child have an IEP or IFSP? ☐ Yes ☐ No ☐ Do Not Know **(Attach IEP/IFSP documentation)**

Condition/ Diagnosis (Medical Professional Use ONLY): _____ **(Attach assessment results)**
Diagnosed by: ☐ Pediatrician ☐ Psychologist ☐ Neurologist ☐ Other: _____

Other/Comments: _____

Referring Agency Information:

Name:	Referring Agency/ Program Information:	
Position/Title:	Phone:	Email:
Address:		

Family has already been referred to:	Date Referred:	Family interested in referral for:
☐ Golden Gate Regional Center (GGRC)	_____	☐ GGRC ☐ SFUSD ☐ Beacon/ABA ☐ CCS
☐ San Francisco Unified (SFUSD)	_____	☐ ECE Inclusion Coaching ☐ Child Care ☐ Legal
☐ Beacon/ABA Service	_____	☐ Parenting Skills ☐ Support Group(s) ☐ Housing
☐ California Children's Services (CCS)	_____	☐ Health Insurance ☐ Playgroup(s) ☐ Counseling
☐ Other: _____	_____	☐ Other: _____

Parent/Guardian Consent: Please be advised we will not be able to contact you without written consent from the family.

I give permission to Support for Families, the referring agency, and any agency(ies) indicated above to obtain and exchange pertinent information regarding my child.

Initials I UNDERSTAND THAT:

_____ The shared information will only be used to coordinate and plan resources and referrals for my child and confidentiality will be maintained.

_____ I understand that SFCD staff member(s) will be contacting me to follow up on my concern for my child.

_____ I may rescind my permission at any time by writing a note to the agencies/individuals. Expires: _____

_____ A photocopy of this form is as valid as the original and I request a copy

Parent/Guardian Signature: _____ Date:_____

Parent/Guardian Printed Name:_____