EC0002
Rev. 11/18

REFERRAL FORM (AGES 3-5)

Department of Early Childhood
Lincoln Public Schools

Name: ______________________ Team/Homeschool: ________________ Student ID: ______________

Ref. Date: ____________ DOB: ____________ Race/Ethnicity: ________________ Gender: __________

Primary Language: ____ Interpreter Needed: ______

Referral Source: ____ Referral Source Ph: _______

Parents: ________________________________ Maiden Name: ________________________________

Address: ____ Zip: ______________

Phone: ____

Best time to contact: ____

Ward of the State: ____________________________ Caseworker: _____________________________

Foster Parents/Guardian: ____

Foster Parents/Guardian Address: ____ Zip: ______________

Foster Parents/Guardian Phone: ____

Best time to contact: ____

Preschool ❑ Daycare ❑ Name: ____

Rescreen or previous services: _______________ Primary Physician: _______________________________

Reason(s) for referral: ____

Screening Date: ______________________

Contact Dates: ________________ ________________ ________________

Eval Date: ________________

MDT Date: _______________

IEP Date: ________________

<u>Buildings: Remember to update your Referral Google Doc.</u>