EC0003
Rev. 11/18

EDN REFERRAL (AGES 0-3)

Department of Early Childhood
Lincoln Public Schools

Name: _____ Team/Homeschool: _____ Student ID: _____

Ref. Date: _____ DOB: _____ Race/Ethnicity: _____ Gender: _____

Primary Language: _____ Interpreter Needed: _____

PRC: _____ Referral Source: _____

Referral Source Phone: _____ Referral Update Method: Email or Fax: _____

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: _____

Concern(s): _____

Intake Date: _____ Screening Date: _____ **45 Days:** _____

Contact Dates: _____ _____ _____

Eval/RBI Date: _____

MDT/IFSP Date: _____

Referral Update Date: _____

HHS 6 Date: _____