Initial Referral - Hamilton County
Committee on Preschool Special Education

Child: _____ School District: _____
First, Middle, Last

Foster Child: Y N

DOB: _____ Age: _____ Sex: M F

Native Language: English Other: _____ Racial/Ethnic Category: _____

Parent /Guardian: _____ Relationship to child: _____

Address: _____

Phone: (Home):_____ Phone: (Work/Cell):_____

Emergency Contact Information

Name: _____ Phone: _____

Relationship to Child: _____

Person Making Referral Information

Name: _____ Phone: _____

Relationship to Child: _____

Address: _____

Physician Information

Name: _____ Phone: _____ Fax:_____

Address: _____

Significant health issues/medical alerts:

_____

Current Program/Services: Early Intervention Other: _____

Site/Location: _____

SEIT Provider: _____ Frequency/Duration_____

OT Provider: _____ Frequency/Duration_____

PT Provider: _____ Frequency/Duration_____

Speech Provider: _____ Frequency/Duration_____

Other Provider: _____ Frequency/Duration_____

Reason for referral (describe in detail):

MANDATED COMPONENTS

Psychological
Social/history
Physical
Observation of child

ADDITIONAL ASSESSMENTS

__ PT
__ OT
__ Speech
__ Audiological
__ Functional Behavioral Assessment
__Other: _____

CPSE Chairperson's Signature: _____ Date received: _____

Referral Date: ____/____/_____