

SoonerStart Early Intervention Program Referral Form

Section 1: Child Information						
First Name:	Middle Initial:	Last Name:		SSN:		
Date of Birth:	Age:	Sex:	DHS Custody: <input type="checkbox"/> YES <input type="checkbox"/> NO	Medicaid #:	If none, potentially, eligible? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Ethnicity: Is your child Hispanic or Latino? <input type="checkbox"/> YES <input type="checkbox"/> NO		Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander				
Section 2: Family Information						
Caregiver's Name:		Relationship:	Cell Phone:	Other: <input type="checkbox"/> Home <input type="checkbox"/> Work		
Caregiver's Name:		Relationship:	Cell Phone:	Other: <input type="checkbox"/> Home <input type="checkbox"/> Work		
Additional Contact:		Relationship:	Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work			
Address:		City:	State: OK	Zip:		
Email:		County:	School District:	Health Department:		
Native Language:			Does Family need an interpreter? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Section 3: Referral Information						
Reason for Referral:						
Documentation Received with Referral: <input type="checkbox"/> YES <input type="checkbox"/> NO If so, what:						
Referral Source (Name and Title):			Agency:	Referral Source Email:		
Address:				Phone:		
Are Parents Aware of Referral: <input type="checkbox"/> YES <input type="checkbox"/> NO			How did the referral source hear about SoonerStart?			
Section 4: Office Use						
Date of Referral:	Service Coordinator:			Received By:		
Date Assigned:	IFSP Target Date:			SoonerStart Site:		