GILA RIVER INDIAN COMMUNITY

Early Childhood Special Services

P.O. Box 97

Sacaton, AZ 85147

(520) 562-3882

Fax: (520) 562-3205

Referral for Developmental Screening

(Please Fill Out Completely)

Date: _____

Child's Full Name: _____

Male or Female: _____ Date of Birth: _____ Age: _____

Date (s) & Results of Current Vision Screening: _____

Date (s) & Results of Current Hearing Screening: _____

Parent/Guardian's Name: _____ District: _____

Parent/Guardians' Mailing Address: _____

Directions to Home:

Telephone: (____) _____ Home (____) _____ Work

(____) _____ Cell (____) _____ Message

Referring Person: _____

Referring Agency/Program: _____

Mailing Address: _____

Phone No: (____) _____

Reason for Referral/Parental Concerns:

I understand a representative of GRIC Special Services will be contacting me about this referral for a developmental screening.

Person Receiving Referral: _____ Date: _____

Office Staff Receiving Referral: _____ Date: _____