Gila River Indian Community

Early Childhood Special Services Program

P. O. Box 97 Sacaton, AZ 85147
Phone: (520) 562-3882 Fax: (520) 562-3205

Referral 3-5 Year Olds

Date: ____________ Referring Program/Location: ____

Contact Person: ____ Phone: __________________________

Child's Name: _________________________________ Date of Birth: ________________ Age: _________

Dates/Results of Current Vision Screen: ____

Dates/Results of Current Hearing Screen: ____

Parent/Guardian: ____

Address: ____

Home Phone: ____________________________ Work Phone: ____________________________________

CERTIFICATION: I certify that the Parent/Guardian has been notified of the reason for this referral.

____ __________________________________
SIGNATURE OF PERSON MAKING REFERRAL DATE

Reason for Referral: ____

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Review of existing data must be included in screening instrument and score for each domain:

☐ Observational summary attached ☐ Developmental Screener (ie. Brigance) attached

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Include additional intervention/modification and/or accommodations used in the home or classroom environment setting:

☐ Additional Documentation (observations)

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