This section is Official Use only (IS to copy section to email body): This form is for referrer(s) use. v1-10-2018

45 Day	IS Initials	Process Date	UCI	Last Name	First Name	MO	Language	Co	City/Zip(SF)	HR	Date Assigned	SC Assigned
4/14/20						**0**						

Golden Gate Regional Center – Early Start Referral Form

Date of Referral:	Child's LAST Name:	Child's FIRST Name:	Date of Birth: =0m	Sex:

Person making referral: ☐ Fax ☐ Phone ☐ Email	Referrer's Agency/Organization Name:	Referrer's Phone # / Fax # / Email:

Attached: ☐ ROI (for assessment outcome check) ☐ Developmental Screening Tool ☐ Discharge Summary/ Medical Reports/Notes

☐ **Check if parent(s) is aware of, and agree to, (1) this Early Start referral; (2) potential state fee ($0-200, yearly) beyond assessment and case management services. Children with Medi-Cal and low income families are exempt from fee. Details: http://www.dds.ca.gov/annualfamilyprogram/**

Parent(s) Name: ☐ Check if CPS is currently involved	Language(s) Spoken in House: ☐ Not Fluent in English

Foster Parent's Name: (If applicable)	Contact Phone #:	Contact Email:

Physical Address: ☐ Check if mailing address is different (and list below) ☐ Check if transient	Ethnicity:

Legal Representative/ Educational Rights:	Birth Hospital:	Primary Care Physician/Group:

Therapist/Professionals/Agencies involved (e.g. CPS, ST, OT, PT, CCS, ABA) & Contact Person:	Child's Insurance Provider & #:

please attach any pertinent medical or developmental report to expedite the assessment process

Developmental Delay Please elaborate the delay(s) in detail AND indicate if having significant concern for a specific diagnosis (e.g. autism):

Cognitive .....

Physical/ Motor .....

Vision/ Hearing .....

Communication .....

Social/ Emotional .....

Adaptive/ Self-Help

Established Risk (Specific Diagnosis):

High Risk – A) 2 or more items (attach report):

- ☐ Prematurity of less than 32 weeks gestation and/or birth weight of less than 1500 grams
- ☐ Assisted ventilation of more than 48 hrs during first 28 days
- ☐ Small for gestational age
- ☐ Asphyxia neonatorum - with 5 min. Apgar score 0-5
- ☐ Neonatal seizures or nonfebrile seizures
- ☐ Central nervous system lesion or abnormality
- ☐ Central nervous system infection
- ☐ Multiple congenital anomalies or genetic disorders
- ☐ Clinically significant failure to thrive
- ☐ Persistent hypotonia or hypertonia
- ☐ Prenatal exposure to known teratogens
- ☐ Prenatal substance exposure, positive infant neonatal toxicology screen or symptomatic neonatal toxicity or withdrawal.
- ☐ Severe and persistent metabolic abnormality
- ☐ Biomedical insult including, but not limited to, injury, accident or illness which may seriously affect development outcome

High Risk – B) ☐ Infant or toddler is a child of a person with developmental disability and requires intervention services

Additional Comments/ Other Social Factors:

To check outcome of assessment via Email – only if ROI is attached – intake@ggrc.org with subject "ES – Outcome Check – [referral date]"
To refer via Email – Attach this referral form and related reports to intake@ggrc.org – with subject "New Early Start Referral"
To refer via Fax – Fax#: (888) 339-3306