Birth to Six Referral

Hutchinson Early Intervention Program

Thank you for referring this child to Early Intervention.
Please fax this form to: 320-234-2617, or call Help Me Grow: 866-693-GROW (4769), or log onto www.MNParentsknow.info to complete the referral process.

Child Information

Child's Name: _____ Date of Birth: _____
(Last) (First) (MI)

Gestational Age: _____ Birth Weight: _____ Male Female

Medical Diagnosis(es), if known / Reason for referral: _____

_____

_____

Newborn Hearing Screening result: Pass Fail Retest

Child's Primary (Outpatient) Doctor/Clinic (if known): _____

Physician Phone/ Fax (if known): _____

Other referrals being made on behalf of this child. (If checked, please provide agency name.)

Home Care: _____ Medical Specialists: _____

Public Health Nursing: _____ County DD Workers: _____

Private OT/PT/SP: _____ Other: _____

Parent / Guardian Information

Parent(s)/Guardian: _____ Phone: (H/Cell): _____ (W): _____

Interpreter Needed: No Yes Language: _____

Mailing Address of Parent(s)/Guardian: _____

_____

Referral Source Information

Name of Person Referring / Title: _____ Phone: _____

Hospital / Clinic / Agency: _____ Referral Date: _____

Date Received by School District: _____ Parent is aware of this referral _____