Birth to Kindergarten Referral

Hutchinson Early Intervention Program

Thank you for referring this child to Early Intervention.
Please fill out this form and fax to: 320-234-2617
Or you can make a referral by completing this information online at www.helpmegrowmn.org
Or by calling Help Me Grow: 866-693-GROW (4769)

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 _____