**Simple referral letter two-way consent template**

Practice

Address

Phone

Fax

Dear Child Development Specialist/Health Provider,

On \_\_\_\_\_\_\_\_\_\_\_\_\_\_, we saw \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, age \_\_\_\_\_\_\_\_\_\_\_ , d.o.b. \_\_\_\_\_\_\_\_\_ parents' names(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We viewed \_\_\_\_\_\_\_\_\_\_\_\_\_'s development using:

\_\_screening tools including (list measures)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_assessment tools including (list measures)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_diagnostic measures including: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The results suggest significant challenges in these areas:

\_\_fine motor skills

\_\_receptive language

\_\_expressive language and articulation

\_\_gross motor skills

\_\_self-help skills

\_\_social-emotional-behavioral/mental health skills

\_\_preacademic and academic skills

\_\_chronic illness or other conditions associated with developmental-behavioral problems (list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We have responded by:

\_\_giving parents information on things to do at home

\_\_screening hearing, vision, and lead levels: results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_scheduling a follow-up visit to address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_explaining to parents the need for additional testing of \_\_\_\_\_\_\_'s learning, development and behavior

\_\_recommending that \_\_\_\_\_\_\_\_\_\_\_\_\_\_ receive additional evaluations (list medical subspecialty, therapy or other specialized evaluation services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We would like your program to:

\_\_contact this family to schedule an appointment

\_\_allow our office to schedule an appointment for this family

\_\_give parents information on things to do at home

\_\_provide parent training in developmental promotion

\_\_address issues in parent and child well-being

\_\_arrange for social services to assist with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_administer more detailed measures of learning, development and behavior

\_\_assess these specific area(s) of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in addition to your usual assessments.

\_\_screen \_\_\_\_\_\_\_\_\_\_\_\_\_\_'s \_\_hearing, \_\_vision, \_\_lead levels, \_\_health

I prefer to be contacted by:

\_\_email : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_surface mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_phone at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. The best hours to reach us are \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider

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The parent of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

has indicated below :

\_\_\_ I am willing for information to be sent from this clinic to your services

\_\_\_ I am willing for information to be shared between this clinic and your service

\_\_\_ I am not willing for information to be shared between this clinic and your service

Parents’ names \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If parents have not agreed that you may share information with our clinic, please ask again for permission so that we may best help this family.