Washington State Department of CHILDREN, YOUTH & FAMILIES

Health Care Referral Form

Early Support for Infants and Toddlers (ESIT)

CHILD INFORMATION				
NAME OF CHILD		DATE OF BIRTH		DATE COMPLETED
BIRTH WEIGHT	GESTATIONAL AGE (weeks)	GENDER ☐ MALE ☐ FEMALE	TIME SPENT IN NICU	DATE DISCHARGED
Please check if any of the following apply: ☐ Urgent Referral ☐ Currently in NICU ☐ Currently in Hospital Anticipated Discharge Date				

PARENT/GUARDIAN INFORMATION: ☐ Birth Parent ☐ Foster Parent ☐ Other (specify)		
PARENT/GUARDIAN NAMES:	PRIMARY LANGUAGE	INTERPRETER NEEDED: ☐ YES ☐ NO
PHYSICAL ADDRESS: CITY: STATE: ZIP	COUNTY	ALTERNATE PHONE
PHONE	EMAIL	

REFERRING PROVIDER CONTACT INFORMATION			
REFERRING PROVIDER NAME		SPECIALTY	REFERRING FACILITY
PHONE	COUNTY	EMAIL	
FAX	MAILING ADDRESS: CITY: STATE: ZIP		

What type of follow up would you like? (check one):

☐ First EI visit scheduled ☐ First EI visit completed ☐ Evaluation Report ☐ Individual Family Service Plan (IFSP)

PROVIDER REASON FOR REFERRAL	
IDENTIFIED DIAGNOSES and CPT/ICD- 10 CODES	PRIMARY DEVELOPMENTAL CONCERNS: (check all that apply) ☐ Adaptive ☐ Gross Motor ☐ Cognitive ☐ Social-Emotional ☐ Feeding/Nutrition ☐ Vision ☐ Fine Motor ☐ Hearing ☐ other: (specify)
☐ Diagnosis has a high probability of resulting in a developmental delay. This may allow for automatic eligibility.	**Include all relevant medical assessment, and therapy records with this referral.**
PLEASE DESCRIBE / COMMENTS:	
REFFERING PROFESSIONAL SIGNATURE	DATE

Call Help Me Grow WA at 1-800-322-2588 or check the ESIT website for the central referral contract in your area.
Local Early Intervention/Birth to Three Contact:

**This form adapted for Washington State with permission from Oregon Department of Education (ODE) March 2020*