THE SCHOOL BOARD OF BROWARD COUNTY FLORIDA
Exceptional Student Learning Support

FDLRS / Child Find Referrals for
Children Ages Birth to 5 Years

DIRECTIONS: Facility Director is responsible to ensure the ASQ Questionnaires are administered and that, when indicated, appropriate and timely referrals are made.

1. **USE** *ELC Broward* Referral Form; *see below for fax.*
2. **ATTACH** the ASQ 3 and ASQ/SE screening with the referral.
3. **CHECK** Subsidized child care/School Readiness assistance box (*below*).
4. Parent *must sign* Authorization to Refer.

IF A CHILD FAILS ONE OR BOTH OF THE ASOs AND THE PARENT PROVIDES CONSENT, MAKE REFERRAL WITHIN 48 HRS.

Referred By: _____ **Director's Name:** _____
Child Care Facility

School E-Mail: _____ **School Phone#:** _____ **FAX #:** _____

Referring Source: ELC BROWARD **ASQ 3 & ASQ SE Attached:** ❑ Y ❑ N ❑ New ❑ Annual

Authorization to Refer: _____ _____ _____ _____
Print Parent/Custodial Caregiver's Name *Signature* *Relationship* *Date:*

Child's Name: _____ **DOB:** _____ **Age:** _____ **Sex:** ❑ M ❑ F

Language Spoken at Home: _____ **Family receives subsidized childcare/SR financial assistance?** ❑ Y ❑ N

❑ **Parent** ❑ **Foster Parent** ❑ **Relative** ❑ **Guardian:** _____

Home Address: _____ **Apt #:** _____

City: _____ **State:** FL **Zip:** _____

Home Phone: 954/754 _____ **Work:** 954/754 _____ **Cell:** 954/754 _____

Alternative Contact Name: _____ **Relationship:** _____ **Phone:** _____

Child Covered by Healthcare Insurance? ❑ Y ❑ N ❑ Unknown **Medicaid #:** _____

Private: ❑ Y ❑ N **Name of Insurance Plan:** _____ **Plan #:** _____

Child is currently monitored by DCF/Child Net: ❑ Y ❑ N **ChildNet Advocate:** _____

Developmental / Educational Concerns: ❑ Communication ❑ Motor ❑ Self-Help ❑ Cognitive ❑ Social/Emotional

❑ Behavioral ❑ Other Pertinent Information: _____

Currently Receiving Developmental Services? ❑ Y ❑ N ❑ Physical Therapy ❑ Speech Therapy ❑ Occupational Therapy

❑ Behavioral Services ❑ Unknown **Where?** _____

Child has a Medical Diagnosis ❑ Y ❑ N **What:** _____

Comments _____

FOR CHILD FIND USE ONLY		FOR CDTC USE ONLY / PART C STATUS
FDLRS #: _____		**Part C Eligible** ❑ Y ❑ N **Date:** _____
Date of Referral: _____		**Service Coordinator:** _____
Home School: _____		**Initial IFSP:** _____
Screening Appointment: _____		**Transition IFSP Mtg.:** _____

Fax to: Early Learning Coalition Broward at 954-377-2192 or scan and e-mail to: dkay@elcbroward.org
For More Information, Contact: Debbie Kay, ELC Inclusion/Behavioral Specialist 954-295-0672 (cell)