# ELWYN SEEDS REFERRAL FORM

***PLEASE FAX COMPLETED REFERRAL FORM TO ELWYN SEEDS INTAKE AT 215-823-5083 or email to 3to5EI@elwyn.org

| Date of Referral : |
|---|

| Name of Child: | Date of Birth: |
|---|---|

| Name of Parent/Legal Guardian: | Address (street, city, state, zip): |
|---|---|
| | |
| | Telephone: |
| | |
| Name of Foster Parent (if applicable): | Email: |
| | |
| | Native Language: |

| Preschool/Head Start/Childcare Information: | Address (street, city, state, zip): |
|---|---|
| | |
| | Telephone: |
| | Email: |

| Name of Person Completing Referral: | Telephone: |
|---|---|
| | Email: |

**Area of Concern (please check all that apply)**

_Communication _Speech/Articulation _Communication/Language
_Personal/Social _Fine/Gross Motor
_Other (please explain) ______________________________

**Check if referral being completed by parent/legal guardian:**
___I ________________________ (name of parent/legal guardian) would like to be contacted to coordinate an early intervention evaluation for my child.

**Check if referral is being completed on behalf of parent/legal guardian**:
___I hereby give my permission to ________________________ **(name of referral source)** to release the above information to Elwyn—Philadelphia SEEDS Early Intervention Program for evaluation. **(**You will be asked to sign a Permission to Evaluate by Early Intervention before an evaluation is done on your child)**

______________________________ ______________________
Signature of Parent/Legal Guardian Date

______________________________ ______________________
Signature of Referring Agency Representative Date