

# Medically Complex Care Consultation Program

## Referral Form

Please send the completed form to Kim Kinz

Mail: Criterion Child Enrichment, 300 East Main St. Milford, MA 01757 or Email: [kkinz@criterionchild.com](mailto:kkinz@criterionchild.com)

Phone: 508-498-6983

### Early Intervention Program

Referring Program: \_\_\_\_\_ Date: \_\_\_\_\_

Service Coordinator/Discipline: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Days available (include regular visit time): \_\_\_\_\_ Preferred Contact:  email  phone

**Attach a copy of the most recent IFSP**

### Child/Family Information:

Child Name: \_\_\_\_\_ DOB: \_\_\_\_\_ EICS Enrollment #: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Gender:  Male  Female

Parent(s) Name: \_\_\_\_\_

Address: \_\_\_\_\_ City/Town: \_\_\_\_\_ ZipCode: \_\_\_\_\_

Tel.#: \_\_\_\_\_ Email Address: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Parents Primary Language Spoken: \_\_\_\_\_ Interpreter Needed:  Yes  No

Parents Primary Language Written: \_\_\_\_\_ Translation Needed:  Yes  No

### Diagnosis/Reason for Referral.

Ongoing Medical Specialists (3 or more specialists qualify a child for the MC3 Program)

Please List:

Multiple Diagnosis/Disabilities (ASD, Vision or Hearing Loss alone are not a qualifying diagnosis)

Please List:

**Medical Information**

Health Insurance: \_\_\_\_\_

Pediatrician's Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

**I authorize and request the release of information pertaining to my child's participation in Early Intervention programming to the MC3 Program Coordinator to assist in securing services and program planning for my child and family.**

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

***This form must be signed in order for MC3P to correspond with your EI provider.***

**MC3P Program Status:**

Referral Date: \_\_\_\_\_ Intake Scheduled: \_\_\_\_\_ Intake Completed: \_\_\_\_\_

Enrolled:  YES  NO