Worcester County Early Intervention Consultation Program

Referral Form and Consent for Observation and Assessment

Early Intervention Coordinator: Esther Widra, LCPC

Please email completed Referral and Consent to: esther.widra@maryland.gov

Child's Name: _____Date: _____

Date of Birth: _____

School & Grade: _____ Teacher: _____

School/teacher phone:_____ Email: _____

Does the student have an IEP or 504 Plan? _____

Parent/Guardian's Name(s): _____

Phone: _____

Home Address: _____

Primary language spoken at home: _____

Reason for Referral:

_____

_____

_____

_____

When did behavioral difficulties begin?

_____

Any recent significant changes in the child's life? If yes, please describe

_____

_____

Please check any current areas of concern:

- ☐ Aggression
- ☐ Attention
- ☐ Disruption
- ☐ Seems Depressed
- ☐ Withdrawn
- ☐ Anxiety
- ☐ Self-injury
- ☐ Other _____

Does the child have any established diagnoses?

- ☐ Attention-Deficit Hyperactivity Disorder
- ☐ Speech and Language Delay
- ☐ Sensory Impairment
- ☐ Physical Disability
- ☐ Autism Spectrum
- ☐ Developmental Delay
- ☐ Allergies _____
- ☐ Medical Conditions _____
- ☐ Other _____

What strategies have you tried in the past and did they work?

_____

_____

What are the Child's strengths?

_____

_____

Any other Information:

_____

_____

AUTHORIZATION FOR MY CHILD TO RECEIVE EARLY INTERVENTION CONSULTATION SERVICES

In signing this Authorization Form, I as the parent or guardian understand that:

- I consent to have my child observed and screened to have services rendered as needed
- I will participate in the plan of action process to ensure the appropriate services are implemented for my child. This includes meeting or consulting with the Early Intervention Coordinator via phone, email, virtually, and/or person-to-person, meeting with staff or teachers as needed and following through on recommendations.
- I grant permission to share information with my child's public school staff as needed.
- I may revoke my consent at any time.

I give my authorization to have my child, _____, to participate in the supportive services offered by the Early Intervention Consultation Program at _____ (school/daycare location). I am aware that my child will be observed in the classroom setting. I am aware that I may be requested to participate in meetings in regards to my child's social-emotional well-being. I am aware that I have the right at any time to ask questions concerning this program and the services it has to offer. I am aware that this is a consultation program in which recommendations will be provided. I am aware that it is the responsibility of the parent/guardian to implement the strategies in the home setting and the teacher in the classroom setting.

_____ Date: _____
Printed Name of Parent/Guardian

_____ Date: _____
Signature of Parent/Guardian