NINOS, Inc. Head Start/Early Head Start Program

Intervention Packet

PID: _____

Child's Personal Information

Name _____ Date of Birth: _____

Parent's Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Tel: _____

Insurance Coverage: *Private Insurance:* ☐ *Medicaid:* ☐ *None:* ☐ *E-mail Address:* _____

Enrollment Information

Center: _____ Teacher: _____

Date of Child's Enrollment: _____ Language Child Speaks: _____

Abnormalities on Physical _____

Vision: _____ Hearing: _____

Immunization Complete: _____ LAP-B-K /ASQ Screening: _____ *Pass:* ☐ *Fail:* ☐

Circle One: TSR/CLI/ LAP-B-K/E-LAP Assessment: _____ *Above Average:* ☐ *Average:* ☐ *Below Average:* ☐

Referral Information

Reason for Referral: _____

Parent been Informed: *Yes:* ☐ *No:* ☐ Parent Comments: _____

Is child receiving services anywhere? *Yes:* ☐ *No:* ☐ Agency: _____

Refusal of Services

Reason for Refusal: _____

Supporting Documentation *(Please include supporting documentation with referrals)*

☐ *Intervention Plan* ☐ *Observations* ☐ *Assessment* ☐ *Progress Report* ☐ *Evaluations*

☐ *Other* _____

_____ _____ _____ _____

Parent Signature Date Center Staff Signature Date

_____ _____

Disability Coordinator Signature Date