Phone: (888) 510-1211
Fax: (510) 927-3117

Help Me Grow
Alameda County

PEDIATRIC PROVIDER REFERRAL FORM

Please attach the ASQ, ASQ:SE, M-CHAT or other screening tools and any authorization forms (if available)

Has the family agreed to this referral? Yes ☐ No ☐

Referring Provider Information (Individual who will receive provider feedback)

Referral Date | Referral Site Name | Referring Provider Name | Title

Address | Unit | City | Zip Code

Phone Number
( ) --

Fax Number
( ) --

Did you refer child/family to (check all that apply):

☐ Regional Center of the East Bay (Date Submitted: _____) ☐ EPSDT Mental Health Services (Date Submitted: _____)

☐ SELPA/School District (Date Submitted: _____) ☐ Other: _____ (Date Submitted: _____)

Child's Information

Child's Last Name | Child's First Name | DOB | Gender ☐F ☐M

Address | Unit | City | Zip Code

Child's Health Insurance (if known):

Parent / Caretaker's Information

Parent/Caregiver Last Name | Parent/Caregiver First Name | Relationship to Child | Language(s) Spoken

Best Phone (check one) ☐ Home ☐ Work ☐ Cell
( ) ---

Other Phone (check one) ☐ Home ☐ Work ☐ Cell
( ) ---

Email

Parent/Caregiver Last Name | Parent/Caregiver First Name | Relationship to Child | Language(s) Spoken

Best Phone (check one) ☐ Home ☐ Work ☐ Cell
( ) ---

Other Phone (check one) ☐ Home ☐ Work ☐ Cell
( ) ---

Email

Reasons for Concern/Referral (check all that apply)

DEVELOPMENT

☐ Age-appropriate adaptive skills
☐ Cognitive/Learning
☐ Communication/Language Development
☐ Fine Motor
☐ General Developmental Guidance
☐ Gross Motor
☐ Other:

BEHAVIOR AND FAMILY

☐ Behavioral Concerns
☐ High Family Stress
☐ Parent-Child Relationship
☐ Parent Support and Education
☐ Sensory Concerns
☐ Social Skills/Social Emotional
☐ Trauma/Adverse Childhood Experiences-**SCORE**_____

HEALTH AND GENERAL SUPPORT

☐ Basic Needs
☐ Child Care
☐ Community Resources/Information
☐ Health/Medical
☐ Hearing/Audiology
☐ Vision

Other comments/notes/Reasons for Referring to Help Me Grow: