



infant toddler services of kansas

Serving Northeast Kansas

Serving Atchison, Brown, Doniphan, Jackson, Jefferson, Nemaha, and USD 343 in Douglas and USD 322 in Pottawatomie

Please complete this form to refer a child to Infant Toddler Services of Kansas.

Please indicate the feedback that you would like to receive from the Early Intervention Program in response to your referral. Primary referral sources must make a referral as soon as possible, but not more than seven days after the child has been identified as needing further evaluation.

Parent/Child Contact Information

Child First Name: _____ Middle Initial: _____ Last Name: _____
 Date of Birth: ____/____/____ Child Age (Months): _____ Gender: M F
 Home Address: _____ City: _____ State: ____ Zip: _____
 Parent/Guardian _____ Relationship to Child: _____ E-mail: _____
 Primary Language Spoken in the Home: _____ Home Phone: _____ Other Phone: _____

Reason(s) for Referral to Early Intervention

(Please check all that apply)

- Identified condition or diagnosis (e.g., spina bifida, Down syndrome): _____
- Suspected developmental delay or concern (Please indicate areas of concern):
 Motor/Physical Cognitive Social/Emotional Speech/Language Behavior Other _____
- At Risk (Describe risk factors): _____ Other (Describe): _____

Referral Source Contact Information

Person Making Referral: _____ Date of Referral: ____/____/____
 Address: _____
 Office Phone _____ Office Fax: _____ E-mail _____

Local Infant Toddler Services of Kansas Program Information

Program Name: Infant Toddler Services of Kansas - Serving Northeast Kansas
 Address: 500 E. Sunflower Blvd. City: Ozawkie State: KS Zip: 66070
 Office Phone: 785-213-2614 Office Fax: 785-380-5010 Email: nekits@keystonelearning.org

Feedback Requested by the Referral Source

Date Referral Received: ____/____/____ Date of Initial Appointment with Child/Family: ____/____/____
 Name of Assigned Service Coordinator: _____
 Office Phone: _____ Office Fax: _____ E-mail: _____

After initial appointment, please send the following information:

- | | |
|---|--|
| <input type="checkbox"/> Status of Initial Family Contact | <input type="checkbox"/> Changes in Services Being Provided |
| <input type="checkbox"/> Developmental Evaluation Results | <input type="checkbox"/> Periodic Progress Reports/Summaries |
| <input type="checkbox"/> Services Being Provided to Child/Family
(Including: names of providers and frequency of services) | <input type="checkbox"/> Individual Family Service Plan (IFSP), if developed |
| | <input type="checkbox"/> Other (describe): _____ |

Release of Information Consent

Note to providers: Parental consent is not necessary in order for a referral to be made.

I, _____ (print name of parent or guardian), give my permission for the early intervention program to share developmental and educational information regarding my child, _____ (print child's name), with the provider who referred my child to ensure the provider is informed of the results of the evaluation.

Parent/Legal Guardian Signature _____ Date: ____/____/____

Your consent is effective for a period of one year from the date of your signature on this release.

Please send the completed form to Northeast Kansas Infant Toddler Services
 Email: nekits@keystonelearning.org or Fax: 785-380-5010

*We also accept referrals electronically via a referral form on our website: www.nekits.org