NEEDS ASSESSMENT & REFERRAL

Parent Name (Print) _____ Family ID _____

SPECIAL NEEDS - *Do you suspect, or does your child(ren) have difficulties with…*

Section 1 - *If you suspect your child(ren) may have difficulties in one of the areas, please mark the box below:*

❑ **Hearing** Child's Name & DOB _____ _____	❑ **Learning** Child's Name & DOB _____ _____	❑ **Speech** Child's Name & DOB _____ _____
❑ **Sight** Child's Name & DOB _____ _____	❑ **Behavior** Child's Name & DOB _____ _____	❑ **Physical Development** Child's Name & DOB _____ _____

Would you like information or referrals for:

❑Choosing Childcare ❑ Nutrition ❑ Health/Immunizations
❑Parenting ❑ Family Counseling ❑ Financial Assistance/Food Stamps
❑ Other:_____

Section 2 – *If you **did not mark** any of the boxes above, please fill out this section:*

❑ My child(ren) do(es) not have any of the difficulties with any of the areas mentioned above.

❑ I do not need any referrals at this time.

Parent Signature _____ Date _____

FOR OFFICE USE ONLY	
Referrals given:	
Referral Type	***Date***
1.	
2.	
Referrals given by:	