Early Intervention/Preschool Referral
Case History

To Be Completed on Children Birth-5 years

Brief Description of concern_____

_____

Strengths: _____

_____

IDENTIFYING INFORMATION:

Child's Name_____ Date of Birth_____ Age____ Sex____

Address_____ Phone Number_____

Child lives with ____Both parents ____Mother ____Father ____Stepmother ____Stepfather ____Other adults-please specify _____

Father's Name_____ Business Phone_____ Work Hours_____

Is it ok to call work? ___yes ____no Occupation_____ Age_____

Mother's Name_____ Business Phone_____ Work Hours_____

Is it ok to call work? ___yes ____no Occupation_____ Age_____

Brothers & Sisters (please include name and ages)_____

_____

Family Physician Name & Phone _____

Other Specialists Name & Phone_____

Daycare/Other care Provider _____

BIRTH HISTORY & DEVELOPMENTAL MILESTONES:

Were there any problems during pregnancy with the child? ____Yes ____No Please explain, if yes_____

_____

Birth was: _____Premature (months/wks_____) _____Full-term

Length of labor_____ Birth Weight_____ Was there a cleft palate/lip __Yes __No

Did your child have difficulties during or immediately after the birth?_____

_____

Developmental Milestones (what age was your child able to:)

Sit along _____months Crawl _____months Walk alone _____months

Speak first words _____months Speak sentences _____months

Completely toilet trained _____months

Speech and Language

Did your child coo and babble different sounds during the first 6 months? __Yes __No

Did your child respond to sounds or familiar voices during the 1st year? __Yes __No

Age of child's first word (other than mama or dada)_____

Describe, as detailed as possible, the problem you feel your child is having with his/her speech, language and/or hearing:_____

_____

_____

Have other people noticed this same problem? ___ Yes ___ No

Have you sought professional advice about your child's speech, language or hearing problems before? ___ Yes ___ No Was therapy provided? ___ Yes ___ No

Can your child imitate new/familiar words when you say them for him/her? __Yes __No

Is your child ever frustrated at not being able to communicate? ___ Yes ___ No

Can your child carry out your directions without help? ___ Yes ___ No

Is your child's voice often hoarse or scratchy sounding? ___ Yes ___ No

Does your child repeat words, parts of words or "blocks" his/her airflow when talking? ___ Yes ___ No

Do others understand what your child says? ___ Yes ___ No

Medical History:

Please indicate which, if any, your child has experienced and at what age they began:

Allergies_____ Breathing difficulties_____ Ear infections_____

Hearing loss_____ Head Injuries_____ Seizures_____

Prolonged high fevers_____

Have there been frequent colds ___ Yes ___ No

Have there been vision concerns ___ Yes ___ No

Has your child had, or currently has, tubes put in his/her ears? ___ Yes ___ No

At what age were they placed? _____ Were there issues with them?_____

_____

Are there other medical conditions/surgeries that might have impacted your child's development?_____

Current Medications_____

Behaviors/Skills Observed:

Please check the behaviors that your child exhibits. Any specific descriptions or examples are appreciated.

Observed Skills/Behavior	Frequently Noted	Occasionally Noted	Seldom/ Not Applicable
Eating/Drinking Problems	_____	_____	_____
Toileting Problems	_____	_____	_____
Dressing/undressing problems	_____	_____	_____
Sleeping problems at night	_____	_____	_____
Withdrawn/will not speak up	_____	_____	_____
Cannot follow simple directions	_____	_____	_____
Refuses to do as asked	_____	_____	_____
Speaks inappropriately… (threatens/curses)	_____	_____	_____
Bites nails or sucks thumb	_____	_____	_____
Easily tires	_____	_____	_____
Difficulty crawling, walking, running	_____	_____	_____
Difficulty with coloring, drawing, cutting	_____	_____	_____
Cries	_____	_____	_____
Temper tantrums	_____	_____	_____
Specific fears of person/place/thing	_____	_____	_____
Shows off/seeks attention	_____	_____	_____
Overly self-confident	_____	_____	_____
Overly sensitive to criticism	_____	_____	_____
Cannot wait or take turns	_____	_____	_____
Difficulty changing activities/ perseverates	_____	_____	_____
Short attention span; easily distracted	_____	_____	_____
Overly active	_____	_____	_____
Does not play with other children	_____	_____	_____

Demands immediate rewards or help	_____	_____	_____
Lies/denies obvious truths	_____	_____	_____
Blames behaviors on others	_____	_____	_____
Hurries through activities, gives up easily	_____	_____	_____
Lacks concern for personal safety	_____	_____	_____

Do you have a family history of learning disabilities, mental handicap, speech/language difficulties, hearing loss? ___Yes ___ No (Circle all that apply.)

_____ _____

Signature of person making the referral Date

_____ _____

Signature of Administrator for District Date

Thank you for taking the time to complete this information. Please send completed referral form to: Your local school district OR ESU #5 900 W. Court, Beatrice, NE 68310

_____

Date received at the district