# EARLY LEARNING
COALITION OF HILLSBOROUGH COUNTY

**Inter-agency Referral Form**
**Screening & Support Team**

## Client/Child Information

Child's Legal Name: _____ DOB: _____

Physical Address: _____ Phone: _____

Mailing Address (if different): _____ Alternate Phone: _____

Mother's Legal Name: _____

Father's Legal Name: _____

Guardian: ☐ Mother  ☐ Father  ☐ Mother & Father  ☐ Other

## Referral

Major concerns for referral: _____
_____
_____
_____

Is the child in child care or school program?: ☐ Yes  ☐ No

If yes, where:

Child Care Provider Name: _____ Phone: _____

Address: _____
　　　　(street)　　　　　　　　(city)　　　　　　(state)　　(ZIP code)

### Other Services/Agencies & Contact Person

_____

Case Manager_____

Case Supervisor_____

_____

_____

### Referral Source

Name _____

Address _____

Phone _____

Fax _____

Agency_____

## Consent Statement For Referral Alert

I agree to this Referral Alert being sent to the following agency(ies) for the purpose of obtaining help. **This consent is valid for 90 days from the date of signature.**

_____　　　_____

Parent/Guardian Signature　　　　　　　　　　　　Date

Please complete and upload this form to
**Screening and Support Team Dropbox (Click Link)**