Washington State Department of Early Learning

Early Support for Infants and Toddlers

ESIT REFERRAL FORM - ESD 112

2500 NE 65th Ave, Vancouver, WA 98661-6812
(360)750-7507 Fax (360)906-1010

Referring Staff/Agency: _____ Provider: _____

Staff Contact Number: _____ Date: _____

Parents Name: _____

Child's Name: **Date of Birth:** _____

Address: _____ Phone: _____

City: _____ Washington Zip Code Alternate Phone: _____

Preferred Language: _____

Interpreter Needed: ☐ Yes ☐ No

Why is this child being referred?

I acknowledge that this is not an application for enrollment, but a statement that I am interested in receiving a phone call from ESIT staff. I give my permission to release this information to the Early Support for Infants & Toddlers Program.

Parent Signature: _____ **Date:** _____

Or, Verbal Consent Received via Phone:

Referring physician or staff has had discussion with the parent regarding Early Intervention referral and parent consents to being contacted by the Early Support for Infants and Toddlers Program.

Verbal Consent Received By: _____ **Date:** _____

"It is the policy of ESD112 that no person shall be subjected to discrimination in any aspect of its programs or by its contractors because of race, color, religion, sex, sexual preference, marital status, age, creed, national origin, sensory, physical, or mental handicap, or status as Vietnam-era veteran or disabled veteran."