EARLY STAGES
REFERRAL FORM

DISTRICT OF COLUMBIA PUBLIC SCHOOLS

EARLY STAGES

Today's Date *(mm/dd/yyyy):* _____

Child Name: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female

Race/Ethnicity	Check any that apply: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Other Pacific Islander
Hispanic/Latino	Check one ☐ Yes ☐ No
School or Child Care Type	Check any that apply: ☐ Private ☐ Religious ☐ Charter ☐ Child Care ☐ Head Start Program ☐ DC Public Schools ☐ Not Enrolled
School or Child Care Name	

Parent/Guardian Name		Relationship to Child	
Street Address		Home Phone	
City/State/Zip		Other phone	
Parent/Guardian Primary Language		Child Primary Language	
Parent/Guardian Email			
Reason for Referral			

Referrer information (please complete if you are not the parent of the child being referred).

Referrer Organization			
Referrer Name		Referrer Phone	
Referrer Email		Organization Phone	

Additional information (please complete if known).

Pediatrician Name			
Pediatrician Email		Pediatrician Phone	
Social Worker Name		☐ This child is involved with Children and Family Services (CFSA)	
Social Worker Email		Social Worker Phone	

Parent/Guardian Review (check all that apply):

☐ I have reviewed this referral. I understand this referral begins a process that will determine my child's eligibility for special education or equitable services. I understand I can stop this process at any time.

☐ I give consent for DCPS to share the results of my child's screening and evaluation with the person making this referral.

Sign Here

Parent/Guardian Signature: _____ Date: _____