

# Peñasco ISD

## CHILD FIND REFERRAL PACKET CHECKLIST

- ASQ:3 Screening Packet
- Birth Verification
- Physical
- Vision Results
- Hearing Results
- Current Immunizations
- ASQ-SE2 completed by Parent and Teacher attached
- If referring for Social Emotional Concerns? ☐ **N/A (No SE concerns)**

Child's Name: \_\_\_\_\_

\_\_\_\_\_  
Staff Completing Referral

\_\_\_\_\_  
Service Specialist or Reviewer

Date scanned to Component Manager: Date \_\_\_\_\_

### **Health and Medical Information:**

Name of Primary Care Physician/Clinic: \_\_\_\_\_ Telephone: \_\_\_\_\_

If child sees a specialist: Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Telephone: \_\_\_\_\_

Has this child had lead screening and/or blood test? ☐ Yes ☐ No If yes, ☐ Not Detected ☐ Detected

Were there any medical concerns during the pregnancy or delivery? ☐ Yes ☐ No

If yes, please explain: \_\_\_\_\_

Did your child have any medical concerns when they were a newborn? ☐ Yes ☐ No

If yes, please explain: \_\_\_\_\_

Is child currently on medication? ☐ Yes ☐ No

If yes, explain what medication, frequency taken, and reason taken: \_\_\_\_\_

Has your child been on any medication regularly in the past? ☐ Yes ☐ No

If yes, explain what medication, frequency taken, and reason taken: \_\_\_\_\_

Are there any hearing or vision concerns for the child? ☐ Yes ☐ No

If yes, please explain why: \_\_\_\_\_

#### **Significant Health Problems (for any YES answers, please explain below, including date, frequency, and treatment):**

- |  |  |
|--|--|
| • Asthma   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Allergies (food, seasonal, medication)                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Seizure or Other Neurological Problems                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Infectious or Contagious Disease (Measles, Meningitis, MRSA, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Chronic Illnesses (ear infections, reflux, eczema etc.)            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Hospitalizations / Surgeries (When and what for?)                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Accident/Injuries (When, what happened)                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If yes, please explain: \_\_\_\_\_

#### **Family History (for any YES answers, please explain below):**

- |   |  |
|---|--|
| • Have any family members had similar developmental or health problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Have any family members received special education services?          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Genetic or Congenital Anomalies (birth defects, etc.)                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Vision Problems   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Hearing Problems  | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If yes, please explain: \_\_\_\_\_

## CHILD REFERRAL FORM

*Note: Please complete as many areas as possible; the more info about the child, the more effective the referral.*

**What are the Parent/Family Concerns? (This section MUST be completed; please get family input):**

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**Child has additional evaluation(s) (IFSP, Private Therapy, Autism Eval. etc.) family has provided?** ☐ Yes ☐ No

If yes, list here (attach copies): \_\_\_\_\_

**Classroom/Self-Help Information (please check all items that apply to child being referred):**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Learns new things slowly | <input type="checkbox"/> Difficulty with napping    | <input type="checkbox"/> Difficulty with toilet training           |
| <input type="checkbox"/> Limited interest in toys | <input type="checkbox"/> Difficulty with transition | <input type="checkbox"/> Ongoing difficulty learning class routine |

Other difficulty with classroom/self-help (please describe): \_\_\_\_\_

**Sensory Concerns (please check all items that apply to child being referred):**

**Tactile Touch:**

- ☐ Reacts emotionally or aggressively to touch
- ☐ Doesn't notice drooling
- ☐ Expresses distress during grooming (for example, fights or cries during brushing/washing/nail cutting)
- ☐ Has difficulty standing in line or close to other people
- ☐ Can't stand sand in his/her shoes
- ☐ Doesn't like to be hugged or held
- ☐ Doesn't seem aware of touch sensations

**Taste/Smell:**

- ☐ Limits self to particular food textures/temperatures
- ☐ Picky eater, especially regarding food textures

Other: \_\_\_\_\_

**Auditory/Response to Sound:**

- ☐ Has difficulty paying attention
- ☐ Appears to not hear what you say
- ☐ Is distracted or has trouble functioning if there is a lot of noise around

**Visual/Auditory Sensitivity:**

- ☐ Responds negatively to unexpected or loud noises (ex. Cries or hides at vacuum, hair dryer, etc.)
- ☐ Holds hands over ears to protect from sound
- ☐ Is bothered by bright lights
- ☐ Prefers small, cozy spaces
- ☐ Watches everyone when they move around the room
- ☐ Prefers quiet places

## COMMUNICATION/LANGUAGE/SPEECH:

*Note: Please complete as many areas as possible; the more information, the more effective the referral. If you do not have concerns in an area, be sure to check NO CONCERNS.*

☐ Check if NO CONCERNS about communication/language/speech

### Articulation

#### Intelligibility:

- ☐ Speech is always difficult to understand (20%-40% can be understood)
- ☐ Speech is often difficult to understand (40%-50% can be understood)
- ☐ Speech is sometimes difficult to understand (50%-60% can be understood)
- ☐ Child's vocabulary is too limited to determine intelligibility

#### Voice:

- ☐ Speaks too loudly
- ☐ Speaks too softly
- ☐ Has a chronic hoarse voice
- ☐ Has a nasal voice

#### Fluency:

- ☐ Stutters: ☐ continually      ☐ frequently      ☐ occasionally
- ☐ Repeats: ☐ sounds      ☐ words      ☐ phrases

#### Articulation / Oral Motor:

- ☐ Has trouble saying a few sounds      ☐ Gags/Chokes      ☐ Mouth Breather
- ☐ Has trouble saying many different sounds      ☐ Drools

### Language

- ☐ Seems to have limited vocabulary
- ☐ Often misunderstands what is said to him/her
- ☐ Struggles to find correct words
- ☐ Asks for frequent repetition of instructions
- ☐ Cannot make a sentence of more than 3-4 words
- ☐ When you ask "what is your name" child does not respond
- ☐ Cannot attend to verbal information during circle time
- ☐ Does not understand 1-2 step verbal directions
- ☐ Leaves out "little words" such as the, a, am, of (Ex, "I [am] going to [the] park")
- ☐ Often misunderstands what is said to him/her in one-to-one communication
- ☐ Does not understand concepts easily understood by other children his/her age
- ☐ Uses many non-specific words (ex: it, that, there, stuff) without letting listener know meaning
- ☐ Cannot retell a story or explain a game in a way that listener can understand
- ☐ Puts words in wrong order in sentence
- ☐ Makes up words
- ☐ Changes topics frequently
- ☐ Does not seem to have much to say
- ☐ Cannot point to body parts when asked
- ☐ Cannot sequence ideas appropriately
- ☐ Gives off-topic responses to questions

Other/Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## FINE MOTOR AND GROSS MOTOR:

*Note: Please complete as many areas as possible; the more information, the more effective the referral. If you do not have concerns in an area, be sure to check NO CONCERNS.*

☐ Check if NO CONCERNS about fine motor or gross motor

### Gross Motor:

- |   |  |
|---|--|
| <input type="checkbox"/> Tendency to avoid use of one hand<br><input type="checkbox"/> Trouble catching a ball<br><input type="checkbox"/> Cannot sit still for a period of time<br><input type="checkbox"/> Child cannot kick a ball<br><input type="checkbox"/> Runs into things<br><input type="checkbox"/> Cannot jump with both feet leaving the ground<br><input type="checkbox"/> Difficulty with running, skipping, or hopping<br><input type="checkbox"/> When using one hand, opposite hand will be in motion | <input type="checkbox"/> Trips or falls frequently<br><input type="checkbox"/> Shifts position in chair frequently<br><input type="checkbox"/> Tries to keep work on right or left side of body<br><input type="checkbox"/> Cannot throw ball overhand<br><input type="checkbox"/> Poor one-foot balance<br><input type="checkbox"/> Is unable to walk backwards<br><input type="checkbox"/> Can't walk up the stairs independently (may hold rail)<br><input type="checkbox"/> Other: _____ |
|---|--|

### Fine Motor:

- |  |  |
|--|--|
| <input type="checkbox"/> Difficulty with coloring/drawing<br><input type="checkbox"/> Struggles with buttoning<br><input type="checkbox"/> Movement of total body when writing<br><input type="checkbox"/> Very little movement in fingers/wrist<br><input type="checkbox"/> Cannot copy a straight line when demonstrated<br><input type="checkbox"/> Cannot place pegs into a peg board<br><input type="checkbox"/> When coloring, uses right hand on right side of paper, and left hand on left side of paper<br><input type="checkbox"/> Poor finger coordination- difficulty placing puzzle pieces, making a structure<br><input type="checkbox"/> Cannot use scissors (has had opportunities to be exposed to usage) | <input type="checkbox"/> Difficult to touch fingers to thumb<br><input type="checkbox"/> Moves arm as a single unit (doesn't flex hand)<br><input type="checkbox"/> Tension noted in hand, arm, and/or shoulders<br><input type="checkbox"/> Difficulty stringing beads<br><input type="checkbox"/> Cannot turn book pages 1 at a time<br><input type="checkbox"/> Is unable to use child size tongs to serve food |
|--|--|

When holding a crayon or pencil (check all that apply):

- ☐ Shows clumsy grasp
- ☐ Too heavy pressure on paper
- ☐ Too light pressure on paper
- ☐ Keeps changing grasp
- ☐ Too loose grasp
- ☐ Too tight grasp

Other/Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SOCIAL-EMOTIONAL DEVELOPMENT:**☐ Check if NO CONCERNS about social-emotional development***OR, check all items that apply to referred child***

3+ Times a Day	1-2 Times a Day	1-3 Times a Week	N/A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yells or screams when angry
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Uses obscene language
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does not follow instructions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easily distracted
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cannot remain still
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is aggressive towards peers(hits, bites, etc)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is aggressive towards adults(hits, bites, etc)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is self-abusive (biting, head banging)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has tantrums/outbursts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Damages property intentionally
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Will not participate in class activities
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disturbs other children intentionally
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty sharing/taking turns
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty transitioning from activities
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Quick to react with big emotions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Doesn't usually play with other children
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Not fearful or scared of strangers
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cries for unusual amounts of time
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Appears sad or depressed, doesn't smile
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lacks confidence
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is afraid or fearful
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Complains of pain (stomach pain, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty maintaining personal space
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty managing big emotions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Demonstrates unusual behavior (explain below)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leaves the group without prompting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Places self in danger (Running away, jumping off of furniture, etc.)

**Movement:**

- ☐ Makes noise for no reason, randomly
- ☐ Can't sit still, fidgets
- ☐ Overly excited during movement activity
- ☐ Touches people and objects
- ☐ Jumps from one activity to another so much that it interferes with play
- ☐ Wanders around room inattentively

**Referral Considerations:**

Is this child's behavior the same at home and at school? ☐ Yes ☐ No

Do the parents have concerns about the child's behavior at home? ☐ Yes ☐ No

Have there been any stressful events in the child's life recently? ☐ Yes ☐ No

Child's Strengths: \_\_\_\_\_

\_\_\_\_\_

Other observations/additional information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CONSENT FOR OBSERVATION/SCREENING**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
\_\_\_\_\_

Mailing Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Parent's Primary Language: \_\_\_\_\_ Child's Primary Language: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

**DENIAL FOR OBSERVATION/SCREENING CONSENT**

I understand the reason for the observation/screening, but I do not want my child observed/screened at this time. I understand I may request an observation/screening at a later time.

\_\_\_\_\_  
Parent/Guardian Signature\_\_\_\_\_  
Date

## PARENT CONSENT TO EXCHANGE CONFIDENTIAL INFORMATION

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I give PISD permission to request and/or release information to the following agencies and/or persons, pertinent information about the above child for whom I am legally responsible. In granting consent, I understand that such information will remain confidential, and that such information will be used to provide the child with the best possible professional help.

### INFORMATION WILL BE RELEASED/REQUESTED TO AND/OR FROM THE FOLLOWING:

☒ Child Find INFORMATION RELEASED (only to be released if child is referred for further evaluation)

Birth Certificate Minimum Identifier form	Custody Papers (if applicable)
Immunization up-to-date copy	Lead Screening/Test
Physical form copy	Hearing Results copy
Vision Results copy	

<input checked="" type="checkbox"/> Child Find	<u>INFORMATION REQUESTED</u>	<u>ADDRESS</u>	<u>ZIP</u>
	IEP	12 School Road	87553
	Progress Report	Penasco, NM	
	EDT Evaluation Report		
	Other: _____		

☐ \_\_\_\_\_ Information RELEASED/REQUESTED (only to be released if child is referred for further evaluation)

Other Agency

<input type="checkbox"/> Birth Certificate Minimum Identifier form	<input type="checkbox"/> Custody Papers (if applicable)
<input type="checkbox"/> Immunization up-to-date copy	<input type="checkbox"/> Hearing Results copy
<input type="checkbox"/> Physical form copy	<input type="checkbox"/> IEP/IFSP
<input type="checkbox"/> Vision Results copy	<input type="checkbox"/> Evaluation (specify) _____
<input type="checkbox"/> Other: _____	

☐ Early Intervention \_\_\_\_\_

Name of Agency Address/Zip

INFORMATION REQUESTED: \_\_\_\_\_

I hereby give my consent for the exchange of this confidential information with the above listed agencies. I understand that this consent is valid for a period of one year from the date of signature and that any requests for confidential information after that date will require a new consent form.

_____ Parent/Guardian Signature	_____ Date
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### DENIAL FOR CONSENT

I do not give consent for information to be released at this time.

_____ Parent/Guardian Signature	_____ Date
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