

Arrowhead Head Start
CHILD REFERRAL FORM
(revised September 2026)

- Save As...
- Electronic naming convention: CRF – SiteName - ChildFirstName ChildLastName – Date of Referral
- Email completed form to: Disability and Mental Health Manager **AND** Data Entry Specialist

Check **ALL** referrals types you would like to request for this child – **MULTIPLE referrals can be made using one form.**
For **ALL** referrals checked, complete the corresponding section(s) below

- ☐ Early Childhood Special Education (ECSE) ☐ Social-Emotional Observation
☐ Mental Health Services by Outside Agency

HS Staff Name: _____ Date of Referral: _____

Complete the following section for ALL referrals –

In order to fully complete our community partner referral requirements, **ALL** items are required.

Child Name: _____ CPID #: _____ HS Site: _____

Date of Birth: _____ Child's Age: _____ Gender: ☐ Male ☐ Female

Child Resides With: ☐ Parent/Guardian ☐ Other Family Member ☐ Foster Parents ☐ Other _____

Parent/Guardian(s) Name (First, Last): _____

Address: _____ City: _____ Zip: _____

Primary Phone: _____ Secondary/Contact Phone: _____

Interpreter needed? ☐ Yes ☐ No

If yes, interpreter for: ☐ Child ☐ Parent/Guardian ☐ Both Interpreter Type? _____
(ex: Sign Language, Spanish, etc.)

Developmental Screening Score: _____

Social-Emotional Screening Score: _____

Complete this section IF you checked Early Childhood Special Education (ECSE):

- **Consent for Release of Information is required.** ☐ Consent Signed and returned to Virginia Office?

Parent Response to Referral: ☐ Consented ☐ Refused If refused, reason: _____

☐ This is a parent request for a special education referral

Reason for referral:

☐ Known medical diagnosis:

☐ Suspected disability (check all areas of concern):

- ☐ Cognitive ☐ Social/Emotional/Behavior ☐ Speech/Language ☐ Gross Motor
☐ Fine Motor ☐ Adaptive/Self Help ☐ Other _____

Please describe in detail the reason, situations, and behaviors you have observed relating to this **ECSE** referral.

Complete this section IF you checked Social-Emotional Observation:

- No Consent for Release of Information required.
- Strength and Difficulties Questionnaire (SDQ) is required.
- Email completed SDQ with this referral form.

Parent Response to Referral: ☐ Consented ☐ Refused If refused, reason: _____
☐ This is a parent request for Social-Emotional Observation

Behaviors observed:

- | | | |
|---|---|---|
| ☐ Physical Aggression | ☐ Disruption/Tantrums | ☐ Running Away/Leaving Designated Area |
| ☐ Verbal Aggression/Inappropriate Language | ☐ Noncompliance/Not Following Directions | |
| ☐ Other | | |

Please describe in detail the reason, situations, and behaviors related to this **SOCIAL-EMOTIONAL OBSERVATION** referral, include number of Behavior Incident Reports (BIR) you have completed at the site.

Complete this section only IF you checked Mental Health Services by Outside Agency (ie: ADAPT/CTSS):

- Strength and Difficulties Questionnaire (SDQ) is required. Email completed SDQ with this referral form.
- Consent for Release of Information is required. ☐ Consent Signed and returned to Virginia Office?

Parent Response to Referral: ☐ Consented ☐ Refused If refused, reason: _____
☐ This is a parent request for a MH Outside Agency referral

Referral/Outside Service Requested:

☐ Agency _____

Please describe in detail the reason, situations, and behaviors related to this **MENTAL HEALTH SERVICES BY OUTSIDE AGENCY** referral.