

**SCOTCH PLAINS-FANWOOD DEPARTMENT OF SPECIAL SERVICES
PRESCHOOL REFERRAL**

DATE: _____

CHILD'S NAME: _____

NICKNAME: _____

ADDRESS: _____

TELEPHONE: Home _____

Business _____

DATE OF BIRTH: _____

MOTHER'S NAME: _____

FATHER'S NAME: _____

BROTHERS: _____ (Ages)

SISTERS: _____ (Ages)

Briefly describe your impression of your child's needs as you see them, i.e. communication, social, motor or learning:

At what age were these needs recognized? _____ Have there been changes since then _____?

Please explain: _____.

Has your child's pediatrician noted concerns regarding his/her development? _____

_____.

Does your child have any medical conditions that require special attention? _____.

Has your child had ear infections? If so, how many? _____.

Does your child have any allergies? If so please list _____.

Has your child been seen for a neurological evaluation, other medical evaluations or audiological or vision examinations?

If "yes" by whom, where, when and with what results. Are reports of evaluations available? _____

Has your child been in an Early Intervention Program? _____ What services were provided in that program?

Has your child been seen elsewhere for consultation of therapy services? _____ If "yes" by whom, where, when and

with what results. Are reports of evaluations available? _____

Is there a family history of speech/language, motor or learning problems? _____ If "yes" please explain. _____

Does your child attend a preschool program, daycare or playgroup? _____ If so where? For how long? _____

Has the staff shared any concerns with you? _____ If "yes", please explain _____
