

**Need or Referral  
Head Start/Early Head Start**



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

\_\_\_\_\_  
Name of Person Requesting Referral

\_\_\_\_\_  
Name of Person Receiving Referral

\_\_\_\_\_  
Campus/District

\_\_\_\_\_  
Family Name

\_\_\_\_\_  
Teacher Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date Entered Into PROMIS

<b>Family Services</b> <input type="checkbox"/> Family Crisis – Emergency <input type="checkbox"/> 3 Consecutive Days Absent <input type="checkbox"/> Other	<b>Disabilities</b> <input type="checkbox"/> Observation for possible LEA referral <input type="checkbox"/> Assistance with modifications/adaptations or instructional strategies <input type="checkbox"/> Notification of referral to LEA SpEd – Indicate date _____ LEA referral was made
<b>Educational Services</b> <input type="checkbox"/> Consultation <input type="checkbox"/> Other	<b>Mental Health</b> <input type="checkbox"/> Social/Emotional Concerns <input type="checkbox"/> Other
<b>Health Services</b> <input type="checkbox"/> Health Concerns <input type="checkbox"/> Medicaid/Health Ins. Assistance	<b>Nutrition</b> <input type="checkbox"/> Nutritional Concerns <input type="checkbox"/> Other
<b>Did child see school nurse?</b> Circle:        Yes                    No	<b>Additional Needs:</b>   

**Purpose/Need:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Person Requesting Referral

\_\_\_\_\_  
Date

<b>PERSON RECEIVING REFERRAL</b>	
Action/Follow-up: _____ _____ _____ _____	
_____ Signature of Person Receiving Referral	_____ Date

Additional information can be found in PROMIS.