REFERRAL FORM

This form is for general referrals to Exceptional Parents Unlimited.
Many of our programs/services have eligibility requirements which may limit how we can serve you.
However, we will be in touch with you as soon as possible.

PARENT/CAREGIVER INFORMATION

** REQUIRED FIELD*

*** FULL NAME** _____

DATE OF BIRTH (MM/DD/YYYY) _____

*** RELATION TO CHILD** _____

GENDER _____

ETHNICITY _____

*** PRIMARY LANGUAGE(S)** _____

*** PHONE** _____ **TEXT** ☐ **Yes** ☐ **No**

E-MAIL _____

*** ADDRESS (STREET, CITY, STATE, ZIP)**

_____

_____

IS THE PARENT/CAREGIVER CONNECTED TO ANY OTHER SERVICES? (IF YES, PLEASE SPECIFY BELOW)

_____

ADDITIONAL NOTES

_____

_____

CHILD INFORMATION

*** FULL NAME** _____

*** CHILD'S DATE OF BIRTH (MM/DD/YYYY)** _____

*** AGE** _____

GENDER _____

ETHNICITY _____

SCHOOL DISTRICT _____

SCHOOL NAME _____

PRIMARY PHYSICIAN _____

TYPE OF INSURANCE _____

IS THE CHILD CONNECTED TO ANY OTHER SERVICES?

☐ CPS ☐ CVRC ☐ SCHOOL DISTRICT ☐ OTHER _____ ☐ NONE

DIAGNOSIS (IF KNOWN) _____

_____

ADDITIONAL NOTES

_____

_____

_____

_____

_____

_____

_____

REFERRAL INFORMATION

AREAS OF SUPPORT REQUESTED (CHECK ALL THAT APPLY)

CHILDCARE

☐ Ages 18-36 months

PARENTING SERVICES (Ages 0-18)

☐ Home Visitation (ages 0-5)

☐ Services in your Neighborhood

☐ Trauma-Informed Care

☐ Parenting Classes (in-person or virtual)

PARENT EDUCATION & SUPPORT (Ages 0-26)

☐ Parent Support (individualized or group)

☐ Workshops and Resources

☐ Collaborating and communicating with your child's school team (SST, IEP, 504)

☐ Support reviewing and understanding your child's IEP, IFSP, or 504 plan

☐ Help navigating Regional Center (requesting assessments/purchase of service/understanding)

OTHER: _____

PRESENTING SYMPTOMS (CHECK ALL THAT APPLY)

☐ Autism

☐ Behavior

☐ Developmental Delay

☐ Domestic Violence

☐ Mental Health

☐ Parent with Intellectual Disability

☐ Prematurity

☐ School Concerns

☐ Speech/Communication Concerns

☐ Substance Exposure

☐ Other _____

_____

FOR REFERRALS FROM OTHER AGENCIES

PRIMARY CONTACT _____

REFERRED BY (AGENCY) _____

PHONE _____ **TEXT** ☐ **Yes** ☐ **No**

EMAIL _____

PLEASE SUBMIT THIS FORM TO: REFERRALS@EPUCHILDREN.ORG