THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
Exceptional Student Education and Support Services

FDLRS / Child Find Referral Form

Children Ages Birth to 5 Years

Information Received By: _____ **Date:** _____ **FDLRS#:** _____

Referred By: _____ **Phone#:** _____ **E-Mail:** _____
Individual's Name *Relationship to Child*

Referring Source: _____ **Source is a Child Protection Agency:** ❑ Y ❑ N
Agency Name *Department*
Source is a CSC-Funded Family Strengthening Program: ❑ Y ❑ N

Child's Name: _____ **DOB:** _____ **Age:** _____

Is child is currently receiving protective services? ❑ Y ❑ N **Through what agency?** _____

Sex: ❑ M ❑ F **Language Spoken at Home:** _____ **Child Discharged from:** ❑ NICU* **Attach Discharge Summary** ❑ PICU ❑ Other

Child attending preschool? ❑ Y ❑ N **Family receives subsidized childcare/SR financial assistance?** ❑ Y ❑ N

❑ **Parent** ❑ **Foster Parent** ❑ **Relative** ❑ **Guardian:** _____

Home Address: _____ **Apt #:** _____ **E-Mail:** _____

City: _____ **State:** FL **Zip:** _____

Home Phone: 954/754 _____ **Work:** 954/754 _____ **Cell:** 954/754 _____

Alternative Contact Name: _____ **Relationship:** _____ **Phone:** _____

Child Covered By Healthcare Insurance? ❑ Y ❑ N ❑ **Unknown / Medicaid #:** _____ **Plan:** _____

Private Insurance: ❑ Y ❑ N **Name of Insurance Plan:** _____ **Plan #:** _____

ChildNet Advocate: _____ **BSO Protective Investigator:** _____ **Investigator's Phone:** _____

Developmental / Educational Concerns: ❑ Communication ❑ Motor ❑ Self-Help ❑ Cognitive ❑ Social/Emotional

❑ Behavioral ❑ Vision Related Diagnosis ❑ Hearing Related Diagnosis ❑ Other: _____

Currently Receiving Developmental Services? ❑ Y ❑ N ❑ Physical Therapy ❑ Speech Therapy ❑ Occupational Therapy

❑ Behavioral Services ❑ Unknown **Where?** _____

Child has a Medical Diagnosis ❑ Y ❑ N **What:** _____ **CMS Client:** ❑ Y ❑ N

Comments: _____

Birthplace: _____

Race: _____

FOR CHILD FIND USE ONLY:		FOR CDTC USE ONLY / PART C STATUS
Home School: _____		**Part C Eligible** ❑ Y ❑ N **Date:** _____
Screening Appointment: _____		**Service Coordinator:** _____
		Initial IFSP: _____
		Transition IFSP Mtg.: _____

Fax referral form to Child Find 754.321.7217