## INTERAGENCY REFERRAL FORM

Serving Alachua, Citrus, Dixie, Gilchrist, Levy, and Marion Counties

| Residence County:                            | Date of Refe            | rral:                    |                        |
|--|-------------------------|--------------------------|------------------------|
| Referring Person:                            | Agency:                 |                          | Phone:                 |
| REF  | ERRAL INI               | FORMATION                |                        |
| Concern: □Learning □Speaking □Behaving       | □Seeing □\              | Walking □Listening □     | Sensory Issues □ Other |
| Comments on Area(s) of Concern:              |                         |                          |                        |
| Medical Diagnosis From Dr.:                  | Previous Evaluation(s): |                          |                        |
| <u>C</u>                                     | HILD INFO               | RMATION                  |                        |
| Last:  | First:                  |                          | Middle:                |
| DOB: Male - Female                           | Race:                   |                          | Declined:              |
|  | Hispanic:               | Non-Hispanic:_           |                        |
| Child's Primary Language:                    |                         | Parent's Primary Langua  | age:                   |
| <u>F</u> /                                   | AMILY INFO              | RMATION                  |                        |
| Parent/Guardian:                             |                         | _Relationship to Child:_ |                        |
| Mailing Address:                             |                         | _City:                   | Zip:                   |
| Street Address:(If different from mailing ad | ddress)                 | City:                    | Zip:                   |
| Best Phone:                                  |                         | Second Phone:            |                        |
| Email:                                       |                         | -                        |                        |
| <u>C</u>                                     | URRENT S                | SERVICES                 |                        |
| Child Care Facility/School:                  |                         |                          |                        |
| Receiving Therapies @:                       |                         |                          |                        |
|  |                         |                          |                        |

## **ADDITIONAL INFORMATION**

## Mail or Fax Referral Form to:

FDLRS/Springs 3881 NW 155th Street Reddick, FL 32686

Toll Free: 1-800-533-0326 Phone: 352-671-6051 Fax: 352-671-6096

