Phone: (888) 510-1211
Fax: (510) 927-3117

Help Me Grow Alameda County

COMMUNITY REFERRAL FORM

Please attach the ASQ, ASQ:SE, M-CHAT or other screening tools and any authorization forms (if applicable)

REFERRING PROVIDER INFORMATION

Referral Date	Referral Site Name	Referring Provider Name	Title
Address	Unit	City	Zip Code
Phone Number ( ) --	Fax Number ( ) --		

Did you refer child/family to (check all that apply):

☐ Regional Center of the East Bay (Date Submitted: __________) ☐ EPSDT Mental Health Services (Date Submitted: __________)
☐ SELPA/School District (Date Submitted: ________________) ☐ Other: __________________ (Date Submitted: __________)

CHILD'S INFORMATION

Child's Last Name	Child's First Name	DOB	Gender ☐F ☐M
Address	Unit	City	Zip Code
Child's Health Insurance (if known):			

PARENT / CARETAKER'S INFORMATION

Parent/Caregiver Last Name	Parent/Caregiver First Name	Relationship to Child	Language(s) Spoken
Best Phone (check one) ☐ Home ☐ Work ☐ Cell	Other Phone (check one) ☐ Home ☐ Work ☐ Cell		Email
Parent/Caregiver Last Name	Parent/Caregiver First Name	Relationship to Child	Language(s) Spoken
Best Phone (check one) ☐ Home ☐ Work ☐ Cell	Other Phone (check one) ☐ Home ☐ Work ☐ Cell		Email

REASONS FOR CONCERN/REFERRAL (CHECK ALL THAT APPLY)

DEVELOPMENT	BEHAVIOR AND FAMILY	HEALTH AND GENERAL SUPPORT
☐ Age-appropriate adaptive skills	☐ Behavioral Concerns	☐ Basic Needs
☐ Cognitive/Learning	☐ High Family Stress	☐ Child Care
☐ Communication/Language Development	☐ Parent-Child Relationship	☐ Community Resources/Information
☐ Fine Motor	☐ Parent Support and Education	☐ Health/Medical
☐ General Developmental Guidance/Tips	☐ Sensory Concerns	☐ Hearing/Audiology
☐ Gross Motor	☐ Social Skills/Social Emotional	☐ Vision
	☐ Trauma/Adverse Childhood Experiences	
☐ Other:		

OTHER COMMENTS/NOTES/REASONS FOR REFERRING TO HELP ME GROW:

By signing this authorization, I am agreeing to this referral to Help Me Grow and I understand that Help Me Grow will contact me.

Parent/Guardian Signature: ____Date:________________________

Help Me Grow
Alameda County

AUTHORIZATION TO SHARE INFORMATION

Please fill out this form if you want your referring provider to receive information from Help Me Grow after we contact you.

Child's Name: ____ **Date of Birth**: ___________________

Parent/Guardian Name: ____

BY SIGNING THIS FORM, I AM GIVING PERMISSION FOR HELP ME GROW TO SHARE INFORMATION WITH

____
(Referring Provider Name)

HELP ME GROW WILL SHARE ONLY THE FOLLOWING INFORMATION:

- **RESULTS OF DEVELOPMENTAL SCREENING**
- **RESOURCES AND REFERRALS THAT MY CHILD RECEIVES**
- **RESULTS OF LINKAGES TO RESOURCES AND REFERRALS**

I UNDERSTAND THAT:

- I agree to allow the Help Me Grow staff to share information about my child with my child's provider as listed above.
- I can end these services at any time by notifying the Help Me Grow phone line at the number below.
- I received a copy of this form and may request a copy at any time by writing to: First 5 Alameda County, 1115 Atlantic Avenue Alameda CA 94501.
- I may cancel any part of this authorization at any time by writing to: First 5 Alameda County, 1115 Atlantic Avenue Alameda CA 94501. The cancellation will take place when F5AC receives the request. F5AC is unable to take back any disclosures already made with my authorization, and is required by law to retain records of the care provided to me.
- Information shared under this authorization can be shared by the agency/provider who receives it. F5AC cannot control what the agency/provider does with this information. In some cases, California law prohibits the agency/provider receiving my health information from making further disclosures of it unless another authorization for that disclosure is obtained from me or unless that disclosure is specifically required or permitted by law. However, it is the agency's/provider's responsibility to determine its legal and other obligations regarding this information and for them to comply with those obligations.
- Photocopies and faxes of this signed authorization shall be treated as originals.

Parent/Guardian Signature: ____Date: ________________________

This Authorization expires one year from date of signature. For more information call 1-888-510-1211.