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

Help Me Grow
Alameda County

COMMUNITY REFERRAL FORM

THIS SIDE MUST BE COMPLETED AND SIGNED

REFERRING AGENCY INFORMATION

(If you would like feedback from Help Me Grow about this referral, please fill out the form on the reverse side)

Referral Date	Referring Agency/Program Name	Staff Name		
Address		Unit	City	Zip Code
Phone Number ( ) --		Fax Number ( ) --		

CHILD'S INFORMATION

Child's Last Name	Child's First Name	DOB	Gender ☐F ☐M
Address	Unit	City	Zip Code

PARENT / CAREGIVER'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 ( ) --	
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 ( ) --	

REASONS FOR CONCERN/REFERRAL (CHECK ALL THAT APPLY)

DEVELOPMENT	SOCIAL-EMOTIONAL/BEHAVIOR	OTHER
☐ Communication/Language Development	☐ Compliance (Ability to follow directions/listen)	☐ Feeding/Nutrition Issues
☐ Cognitive/Problem Solving	☐ Crying /Consoling	☐ High Family Stress
☐ Fine Motor Skills	☐ Coping Skills (Frustration Tolerance)	☐ Overly Sensitive to Noise, Light, Touch or Certain Foods
☐ Gross Motor Skills	☐ Dangerous Behaviors	☐ Parent-Child Relationship or Interaction
☐ Personal-Social	☐ Shy/Withdrawn/Clingy	☐ Parenting/Discipline/Boundaries
☐ Other Reason:	☐ Social Skills	☐ Toilet Training Issues
	☐ Tantrums/Aggressive Behavior	☐ Vision/Hearing

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.