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 available)

Has the family agreed to this referral? Yes ☐ No ☐

REFERRING PROVIDER INFORMATION (INDIVIDUAL WHO WILL RECEIVE PROVIDER FEEDBACK)

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):	Medi-Cal #:	Member ID #:	

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	☐ Sensory Concerns	☐ Hearing/Audiology
☐ Gross Motor	☐ Social Skills/Social Emotional	☐ Vision
	☐ Trauma/Adverse Childhood Experiences-**SCORE**_____	

☐Other:

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