SEAS Medical Provider Referral Form

SEAS is a free resource navigation service for prenatal parents, families with a child 5 and under, and families with a child with a developmental concern 21 and under

Contact:
Phone: (360)715-7485
Fax: (360)676-6729

Parents have consented to this SEAS referral *(referrer's initials required):* _____ Date: _____

Referrer's Information:			
Referrer Org./Agency & Your Role	Referrer's Name:	Phone:	Fax:

Who are you referring to services?	☐ **Parent**	☐ **Child**	☐ **Both**

Family Information:			
Child Name (if referring a child):	DOB:	Sex:	Parent/Guardian Name(s): REQUIRED FOR CALL
Street Address:	City:	Zip:	Phone:
Email(s):			2nd Phone:
☐ The family needs an interpreter. What language? _____			If parent is pregnant, # of weeks? _____ If parent recently gave birth, delivery date: _____

Parent is experiencing *(complete this section ONLY if pregnant or has child under the age of 5):*			
☐ Anxiety/depression/mood changes	☐ Pregnancy loss	☐ Teen pregnancy	☐ NICU stay/baby with medical issues
☐ Recent traumatic birth	☐ Parenting stress	☐ Lack of family/friend support	☐ Other: _____

Please navigate the parent to:			
☐ Parenting Classes	☐ Home Visiting Services (Prenatal & children ages 0- 3)	☐ Basic Needs (WIC, etc.)	☐ Perinatal resources (check any preferences if known):
Other:			☐ Peer support ☐ Therapy ☐ Medication mgmt.

I have concerns about the child's:			
☐ Mental/Behavioral Health	☐ Autism Spectrum Disorder	☐ Education/Learning	☐ Social/Emotional Development
☐ Speech/Language	☐ Physical Development	☐ Cognitive Development	Other:

Please navigate the child to:		
☐ Early Support for Infants and Toddlers (ESIT, Early Intervention, Birth to 3) (ages 0-3)		☐ Mental/Behavioral Health Services
☐ Preschool/Childcare	☐ School District Evaluation/Special Education (ages 3-21)	☐ Other:
☐ GIDES local autism evaluation (ages 10 and under) **Diagnosis code *(required):*** _____		
☐ Clinic-based outpatient specialty therapies ***outside of ESIT or school services.*** **Diagnosis code *(required)*:** _____		
Therapies needed: *(circle priority):* ☐ Speech ☐ Feeding/Oral-Motor ☐ ABA ☐ Occupational ☐ Physical		
PCP Signature (only required for GIDES/Specialty Therapies):_____ **Date:** _____		

PLEASE ATTACH RELEVANT CHART NOTES & SCREENINGS