



SEAS Referral Form: Non-Medical Providers
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?	<input type="checkbox"/> Parent	<input type="checkbox"/> Child	<input type="checkbox"/> Both
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Family Information:			
Child Name (if referring a child):	DOB:	Sex:	Parent/Guardian Name(s): REQUIRED FOR CALL
Street Address:	City:	Zip:	Phone:
Email(s):		2 nd Phone:	
<input type="checkbox"/> The family need an interpreter. What language? _____		If parent is pregnant, # of weeks? _____ If parent recently gave birth, delivery date: _____	

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

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

I have concerns about the <u>child's</u> :			
<input type="checkbox"/> Mental/Behavioral Health	<input type="checkbox"/> Autism Spectrum Disorder	<input type="checkbox"/> Education/Learning	<input type="checkbox"/> Social/Emotional Development
<input type="checkbox"/> Speech/Language	<input type="checkbox"/> Physical Development	<input type="checkbox"/> Cognitive Development	Other:

Please navigate the <u>child</u> to:	
<input type="checkbox"/> Early Support for Infants and Toddlers (ESIT, Early Intervention, Birth to 3) (ages 0-3)	<input type="checkbox"/> Mental/Behavioral Health Services
<input type="checkbox"/> Preschool/Childcare	<input type="checkbox"/> School District Evaluation/Special Education (ages 3-21)
<input type="checkbox"/> Other:	
<input type="checkbox"/> GIDES local autism evaluation (ages 10 and under)- Doctor's referral required. See www.seaswhatcom.org for more information	
<input type="checkbox"/> Clinic-based outpatient specialty therapies <i>outside of ESIT or school services.</i> (Doctor's referral may be required).	
Therapies needed: (<i>circle priority</i>): <input type="checkbox"/> Speech <input type="checkbox"/> Feeding/Oral-Motor <input type="checkbox"/> ABA <input type="checkbox"/> Occupational <input type="checkbox"/> Physical	

PLEASE ATTACH RELEVANT CHART NOTES & SCREENINGS