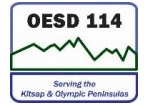




**Olympic Educational Service District 114**  
Early Learning Department  
105 National Ave N Bremerton, WA 98312  
(360) 478-6887 • 1-800-201-1300 • FAX (360) 405-5808



### Referral for Further Evaluation Consent Form

#### Authorization to Disclose the Records of:

Child/Participant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Parent/Guardian Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Reason for Release of Information:** Referral for further developmental and/or social emotional evaluation.

- I authorize mutual exchange of information about my child, as described below, between the following organization/school district and OESD 114 Early Learning Department for the purposes of further developmental and/or social emotional evaluation and service coordination.
- I authorize the organization/school district to contact me to initiate the referral process for my child.

Organization/School: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

#### Referral is for the Following:

- |   |                                       |   |
|---|---------------------------------------|---|
| <input type="checkbox"/> Articulation         | <input type="checkbox"/> Motor Skills | <input type="checkbox"/> Social Emotional |
| <input type="checkbox"/> Language Development | <input type="checkbox"/> Adaptive     | <input type="checkbox"/> Vision           |
| <input type="checkbox"/> Cognition            | <input type="checkbox"/> Behavioral   | <input type="checkbox"/> Hearing          |

#### Documentation Attached:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> ASQ-3              | <input type="checkbox"/> DECA            | <input type="checkbox"/> Three Prong Vision and Hearing |
| <input type="checkbox"/> TS Gold Assessment | <input type="checkbox"/> DRDP Assessment | <input type="checkbox"/> Preschool Hearing and Vision   |

#### My permission is valid for ONE CALENDAR YEAR from signature date.

- I understand all information related to this referral will be treated in a confidential manner and will not be transmitted to a third party without my written permission.
- I understand that it is my right to request a copy of all information as well as to contest any information I feel is incorrect.
- I may revoke or withdraw my permission in writing at any time. I understand this will not affect information already disclosed.

_____ Authorization Signature	_____ Printed Name	_____ Date
_____ Relationship to Child	_____ Phone Number	_____ Organization (if applicable)

If I am not the person who is the subject of the records, I am authorized to sign because I am the:

- Parent       Legal Guardian       Other: \_\_\_\_\_