

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	s 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:		
Phone:	_	Fax:
Referral is for the Following:		
☐ Articulation ☐ Language Development	☐ Motor Skills ☐ Adaptive	☐ Social Emotional ☐ Vision
☐ Cognition	☐ Behavioral	☐ Hearing
Documentation Attached:		
☐ ASQ-3 ☐ TS Gold Assessment	☐ DECA ☐ DRDP Assessment	☐ Three Prong Vision and Hearing☐ Preschool Hearing and Vision
My permission is valid for ONE CALE	NDAR YEAR from signature date	Ţ.
 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)
☐ I/we need interpretive services in this language:		
If I am not the person who is the sub \Box Parent \Box Legal \Box	ject of the records, I am authorized Guardian \Box Other:	to sign because I am the: