1-855-476-9211 • helpmegrowsc.org

Date:____

Name of Child: _____________________________________ DOB: _________________

Mailing Address: ____

City: ______________________ Zip Code: ______________

Phone: __________________________ Email: _____________________________

Parent/Legal Guardian: ____

Language Spoken: ____

Person Referring/Office Name: ____

Referral Source Contact Information -Telephone: _________________Fax: ________________

Is the parent/guardian aware of the referral? □ Yes □ No

Is the referral a result of a developmental screening? □ Yes □ No

If yes, please include a copy of the developmental screening with the referral.

Areas of concern:

□ Gross motor skills

□ Fine motor skills

□ Speech/language skills

□ Continued monitoring of development

□ Prematurity _______weeks

□ Social-emotional

□ Behavioral

□ Parent support/Education

□ Mental health

□ Other: ____________________

Additional information:____

____

Please fax to 864-454-1114 or email to Info@helpmegrowsc.org