Help Me Grow
South Carolina

1-855-476-9211

REFERRAL

Date:_____

Name of Child:_____ DOB: _____

Mailing Address: _____

City: _____ Zip Code: _____

Phone: _____Email: _____

Parent/Legal Guardian: _____

Language Spoken: _____

Referral Source Name/Agency/Office: _____

Referral Source Contact Number: _____

Is the parent/guardian aware of the referral? ❑ YES ❑ NO

Is this referral a result of a developmental screening? ❑ YES ❑ NO

*If yes, a copy of screening must be included with referral

Areas of Concern:

- ❑ Gross motor skills
- ❑ Fine motor skills
- ❑ Speech/language skills
- ❑ Continued monitoring of development
- ❑ Prematurity _____ weeks
- ❑ Special needs
- ❑ Social-emotional
- ❑ Behavior
- ❑ School/preschool issues
- ❑ Parent support/education
- ❑ Mental health
- ❑ Medical
- ❑ Other (please specify):_____

Additional Information:_____

_____

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_____

Please Fax or Email to: **Help Me Grow South Carolina**
864-454-1114
helpmegrowsc@ghs.org