South Central Child Development, Inc.

Developmental Screening Referral Form

Child's Name: ____ DOB: _______________________

Parent/Guardian: ____

Address: ____ Phone: _________________

☐ Permission to refer & release information
☐ Parent declines referral at this time

____
(Parent/Guardian Signature & Date)

Reason for referral:

☐ DIAL-4 scores low in the areas of: ____

☐ Parent or Teacher has concerns in the areas of: ____

Referred to: ____ Date: __________________

LEA/ED Coop

Date: ______________________________________

☐ Child did not qualify for special education services
☐ Child qualifies for services (Attach IEP/Evaluations/Determination of Eligibility)
☐ Parent declined services

Signature/Title: ____

Return to South Central Child Development, Inc 401 Walnut Ave SW, Wagner, SD 57380
605-384-3683 – Fax 605-384-5696