Skagit Preschool and Resource Center
Medical Provider Referral Form – Birth to Three Program

Phone: (360) 416-7570 Fax: (360) 416-7580

REFERRER'S INFORMATION:

REFERRER'S NAME	ROLE	
CLINIC	PHONE	FAX

FAMILY INFORMATION:

CHILD'S NAME	DATE OF BIRTH	GENDER ☐ MALE ☐ FEMALE
PARENT/GUARDIAN'S NAME	PHONE	EMAIL
STREET ADDRESS	CITY	ZIP CODE

I HAVE CONCERNS ABOUT:

☐ SPEECH/LANGUAGE DEVELOPMENT ☐ PHYSICAL DEVELOPMENT ☐ MENTAL/BEHAVIORAL HEALTH
☐ AUTISM SPECTRUM DISORDER ☐ COGNITIVE DEVELOPMENT ☐ SOCIAL/EMOTIONAL DEVELOPMENT
☐ OTHER: _____

IDENTIFIED DIAGNOSES AND CPT/ICD-10 CODES:

☐ DIAGNOSIS HAS A HIGH PROBABILITY OF RESULTING IN A DEVELOPMENTAL DELAY. THIS *MAY* ALLOW FOR AUTOMATIC ELIGIBILITY.

PLEASE NAVIGATE THE CHILD TO:

☐ SPARC EARLY SUPPORT FOR INFANTS AND TODDLERS (ESIT AGES 0-3)

☐ SMART PROGRAM/ASSISTANCE WITH AUTISM EVALUATION (AGES 0-5)

PLEASE ATTACH ANY SUPPORTING DOCUMENTS AND
FAX COMPLETED FORM TO SPARC (360) 416-7580