Family Resource Center
SAN MATEO COUNTY | by abilitypath

REFERRAL FORM

PLEASE RETURN FORM TO THE FAMILY RESOURCE CENTER
Email: info@smcfrc.org | Fax: 650-239-5229

REFERENT

Name of Person Making Referral: _____

Referring Agency: _____

Phone Number: _____ Email: _____

CHILD'S INFORMATION:

First Name: _____ Last Name: _____

Date of Birth (MM/DD/YY): _____

Is child presently receiving Early Start (GGRC) services? ☐ Yes ☐ No

Is child presently receiving Special Education services? ☐ Yes ☐ No

PARENT'S/CAREGIVER'S INFORMATION

Parent's/Caregiver's First and Last Name: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Parent's/Caregiver's First and Last Name: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Address, City, Zip Code: _____

Language(s) spoken at home: _____

Best time to reach parent/caregiver(s): _____

PRESENTING ISSUES/PURPOSE OF REFERRAL (PLEASE CHECK ALL THAT APPLY)

☐ Parent to parent support

☐ Transition to special education services

☐ Child recently diagnosed
(please provide name of diagnosis):

☐ Behavior

☐ Development

☐ Other: _____

By submitting this referral form, I (the provider) have obtained:

☐ Parent/guardian verbal or written consent to refer to the Family Resource Center

☐ Any information shared between staff and family will only be used to coordinate and plan resources and referrals for my child. Confidentiality will be maintained.

☐ **I agree to have a staff member of the Family Resource Center contact me and send me information on services and programs for my child.**

Initials of provider

Parent/Guardian Signature (if available): _____ Date: _____