Cabarrus Care Team

Referral Form

Date of Referral_____

Child's Name _____Date of Birth _____

Child Care Center _____Teacher(s) _____Phone #_____

Parent's Name_____Phone #_____

Home address_____

Doy mi permiso para que los resultados de la evaluación se compartan con el Programa de los Niños Excepcionales Preescolares de las Escuelas del Condado de Cabarrus.

(I give my permission for the results of the screening to be shared with Cabarrus Schools/Kannapolis City Preschool Exceptional Children's Program).

Firma de Padre (Parent Signature)_____Date (Fecha) _____

Vision Pass or Fail Date_____
Snellen Chart or Welch Allyn vision screener
{Please circle instrument used}

Hearing Pass or Fail Date_____
Audiometer or OAE or Welch Allyn Audio Path
{Please circle instrument used}

DIAL 4 Completed on: _____

Results: Motor Score: _____
Concepts Score: _____
Language Score: _____

Notes/Comments:

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**Please include a copy of Health Assessment with this Referral Form*

Contact Elizabeth Albright or Jamie Clark at cabarruscountycareteam@gmail.com for questions.

_____ _____

Child Care Center Representative Date