Wyandotte County Infant Toddler Services

2220 N. 59th St. Suite 114
Kansas City, KS 66104

Phone: 913-627-5500
Fax: 913-627-5501

www.wycoinfanttoddlerservices.org
info.wycoinfanttoddler@gmail.com

Wyandotte County Infant Toddler Services
Referral Form

Please fill out entire form, print a copy for your records, and then email or fax to:
info.wycoinfanttoddler@gmail.com or (913) 627-5501 (fax)
Mark attention to Sonia Lopez: Infant Toddler Services.
If you need assistance, please call WyCo ITS at (913) 627-5500

Referral Source (fill out completely)

Date of Referral: ___________
Name of person / agency making referral: ____
Phone: ________________________________ Fax/Email:____

Reason for referral: ____
Are parents/caregivers aware referral is being made: _____ YES _____NO

Identifying Information:

Child's Name (Last, First, MI): ____
DOB: _____________________ Age: ______________ Male or Female: __________
Who does child live with?
Mother_____ Father_____ Foster _____ Family / Other: ________________________________
Parent:
Name(s): ____
Address (Street, City, State, Zip): ____
Phone(s): ____
Language spoken: ____
Alternative Guardian:
Name(s): ____
Address (Street, City, State, Zip): ____
Phone(s): ____
Language spoken: ____

Ethnicity: ____

Did the child have a low birth weight or substance exposure in utero? _____ YES _____ NO
If yes, fill out questions A-E:

a. Low birth weight: ___________lbs _____________oz
b. Hospital of birth: _______________________________
c. Hospital of NICU stay: _________________________ Discharge Date: ______________
d. Prenatal substance exposure: ____
e. Substantiated abuse or neglect confirmed: YES NO

Automatic Eligibility Information (if applicable)

Identified diagnosis: ____

Where & when diagnosis identified: ____

Has child/parent received outside support for identified condition? _____ YES _____ NO

If yes, what agencies are involved: ____

Please give present levels of concerns for each of the following developmental areas.
If concern is noted, please state reason and if you are referring to an outside source.

Developmental skill	Is there a concern?	Reason for concern & how you came to this conclusion? (observation, assessment, parent report, etc.)	Will you refer outside of ITSWC? (CCHD, KU, CMH, specialty clinic, etc.)
Cognitive Development/Skill Acquisition	YES NO		
Communication/Language	YES NO		
Physical Development (Fine & Gross Motor)	YES NO		
Social-Emotional/ Behavioral	YES NO		
Self-Help/Adaptive Skills	YES NO		

Thank you for engaging in the child find process to determine eligibility for services to Infant Toddler Services. Referral source will receive information on the evaluation **only when ITSWC has obtained informed parent consent to release the information**.

Please contact Debbie Lair for support or clarification at (913) 627-5500 or info.wycoinfanttoddler@gmail.com

Please include attached documents, screenings, and/or assessments.