DeSotoGlades
$\square$ Hendry
$\square$ Highlands

FDLRS Heartland

## CHILD FIND REFERRAL FORM

Local: 863-531-0402 ext. 10712

Toll Free: 1-800-316-7057

Child's Name $\qquad$ Language Spoken $\qquad$ School Zone $\qquad$ Child Care Provider $\qquad$ Birth Date $\qquad$ Birthplace $\qquad$ Sex $\qquad$ Race $\qquad$ Ethnicity $\qquad$ Referred By $\qquad$
Mailing Address $\qquad$ City

## Child Find Specialist:

$\qquad$
Phone: 863-531-0402 ext. $\qquad$

Fax: 863-531-0425

Residence Address $\qquad$ City $\qquad$ Zip $\qquad$
$\qquad$ Phone Number $\qquad$ Other Contact Information Zip $\qquad$
Email Address $\square$
Area of Concern $\qquad$
I would like for my child to participate in the screening activities conducted by the Florida Diagnostic and Learning Resources System.
Parent's Name (Print) $\qquad$ Parent's Signature $\qquad$ Date $\qquad$

## SPACE BELOW IS FOR FDLRS OFFICE USE ONLY

| VISION: |  |  |  | SCREENINGS: |  |  |  |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| LEFT EYE | Could Not Test | Pass |  | Behavior Screener | Pass | Potential Delay | Rescreen |
| RIGHT EYE | Could Not Test | Pass | Refer | Cognition Screener <br> Language Screener | Pass | Potential Delay | Rescreen |
| Screener |  |  |  |  | Pass | Potential Delay | Rescreen |
| Comments |  |  |  | Motor Screener Speech Screener | Pass | Potential Delay | Rescreen |
|  |  |  |  |  | Pass | Potential Delay | Rescreen |
| HEARING: ${ }^{\text {COMMENTS }}$ |  |  |  |  |  |  |  |
| RIGHT EAR | Could Not Test | Pass | Refer |  |  |  |  |
| Screener |  |  |  |  |  |  |  |
| Comments |  |  |  | Child Find Specialist | Dat |  |  |

$\qquad$
$\qquad$

