infant toddler services of kansas
Serving Johnson County

Please complete this form to refer a child to Infant Toddler Services of Kansas.

Please indicate the feedback that you would like to receive from the Early Intervention Program in response to your referral. Primary referral sources must make a referral as soon as possible, but not more than seven days after the child has been identified as needing further evaluation.

Parent/Child Contact Information

Child First Name: _____ Middle Initial:_____ Last Name: _____

Date of Birth: _____/_____/_____ Child Age (Months): _____ Gender: M F

Home Address: _____City: _____ State: _____ Zip: _____

Parent/Guardian_____ Relationship to Child: _____E-mail: _____

Primary Language Spoken in the Home: _____ Home Phone:_____ Other Phone:_____

Reason(s) for Referral to Early Intervention

(Please check all that apply)

☐ Identified condition or diagnosis (e.g., spina bifida, Down syndrome): _____

☐ Suspected developmental delay or concern (Please circle areas of concern):

Motor/Physical Cognitive Social/Emotional Speech/Language Behavior Other_____

☐ At Risk (Describe risk factors): _____ ☐ Other (Describe):_____

Referral Source Contact Information

Person Making Referral: _____Date of Referral: _____/_____/_____

Address: _____

Office Phone_____Office Fax: _____ E-mail_____

Local Infant Toddler Servicesof Kansas Program Information

Program Name: Infant Toddler Services of Kansas - Serving Johnson County

Address: 3 Corporate Woods, 8700 Indian Creek Parkway, #190 City: Overland Park State: KS Zip: 66210

Office Phone: 913-432-2900 Office Fax: 913-432-2901 Email: info@itsjc.org

Feedback Requested by the Referral Source

Date Referral Received: _____/_____/_____ Date of Initial Appointment with Child/Family: _____/_____/_____

Name of Assigned Service Coordinator: _____

Office Phone: _____ Office Fax: _____ E-mail: _____

After initial appointment, please send the following information:

☐ Status of Initial Family Contact

☐ Developmental Evaluation Results

☐ Services Being Provided to Child/Family

(Including: names of providers and frequency of services)

☐ Changes in Services Being Provided

☐ Periodic Progress Reports/Summaries

☐ Individual Family Service Plan (IFSP), if developed

☐ Other (describe): _____

Release of Information Consent

Note to providers: *Parental consent is not necessary in order for a referral to be made.*

I,_____ (print name of parent or guardian), give my permission for the early intervention program to share developmental and educational information regarding my child,_____ (print child's name), with the provider who referred my child to ensure the provider is informed of the results of the evaluation.

Parent/Legal Guardian Signature_____ Date:_____/_____/_____ *Your consent is effective for a period of one year from the date of your signature on this release.*

Please send the completed form to Infant Toddler Services of Johnson County
Email: info@itsjc.org or Fax: 913-432-2901

*We also accept referrals electronically via a referral form on our website: www.itsjc.org

Adapted from *Early Intervention Program Referral Form* developed by the American Academy of Pediatrics (AAP) and the Tracking, Referral, and Assesment Center for Excellence (TRACE) 08/2024