

**Early Start Referral** RCEB Intake Referral Line 510-618-6195; Fax 510-618-7763, Attn: EI Intake

**REFERRAL SOURCE:** (Name of agency or individual) \_\_\_\_\_ Phone \_\_\_\_\_

**CONSENT:** Verbal or written consent by Parent / Legal Guardian is required prior to this referral.  
*Referral cannot be processed if this is not completed.*

1. \_\_\_\_\_ Verbal consent has been obtained from parent / legal guardian for referral of child to: The Early Start Program at Regional Center of the East Bay and/or LEA, and if eligible, they agree to participate.  

**OR**
2. \_\_\_\_\_ I hereby give consent for my child to be referred to The Early Start Program at Regional Center of the East Bay and/or LEA, and if eligible, I agree to participate. I also consent to the exchange of verbal or written information between the referral source and RCEB, and/or LEA to gather information needed for intake.
3. \_\_\_\_\_ As parent or individual legally responsible for this child, I hereby give consent for the information gathered for intake referral purpose to be shared with the qualified specialists evaluating to determine eligibility for Early Start services.

Parent / Legal Guardian Signature \_\_\_\_\_  
Signature Date

Referral Form Completed By \_\_\_\_\_  
Signature Date  
Title Phone

Person giving info \_\_\_\_\_ Relation to child \_\_\_\_\_ Phone \_\_\_\_\_

**Internal Use Only**  
 Referred to  
 RCEB  
 SELPA:  
 Transition  
 ASAP [children  
 30+ months]

**Attempts to contact**  
 Phone message:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Final attempt letter sent:

Child's Name \_\_\_\_\_ AKA \_\_\_\_\_  
Last First Middle

F  M DOB \_\_\_\_\_ SSN \_\_\_\_\_ Ethnicity \_\_\_\_\_

Student # \_\_\_\_\_ District/SELPA \_\_\_\_\_

Lives with  Parent  Legal Guardian  Foster Family  Other \_\_\_\_\_

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone \_\_\_\_\_  
Home Phone Work Phone Cell Phone

E-mail \_\_\_\_\_ Best time to call: \_\_\_\_\_

Other Contact Person  
 (Name / Relationship to Family) \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_

If Child is a Court Dependent, Children & Family Services Worker's Name & ID # \_\_\_\_\_

Agency Address \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax Phone # \_\_\_\_\_

If foster child: Who holds educational rights? \_\_\_\_\_  
 If not parents, have birth parents' educational rights been terminated or limited?  
 Yes\*  No  
\* Please provide written documentation

Birth parent: Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_

Language(s) spoken in Child's Home (%) \_\_\_\_\_ Interpreter Needed?  Yes  No  
 Does family have interpreter?  Yes  No Name: \_\_\_\_\_ Phone \_\_\_\_\_

