Disability Navigator Program
Phone (813) 988-7633 ext 11600
Fax (407) 629-7881

Email:dmccalla@fl.easterseals.com

REFERRAL FORM

REFERRAL SOURCE INFORMATION

Referral by: ______________________________ Date: _________________________

Phone:___________________Fax:_________________________ Email: ____________________

I_________________ (parents name) have provided permission for my child to be referred to the Disability Navigator Program, and I agree to be contacted by the designated Disability Resource Navigator for my area.

Parent/Guardian's signature ____ Date:________________

DEMOGRAPHIC INFORMATION

Client Name:_____________________ Birth Date:_________________ Age: __________

Sex: ☐M ☐F Race: ☐White ☐ African-American ☐⃠ Hispanic ☐ Asian/Pacific ☐ Haitian ☐ Other

Legal status: ☐Minor in parent/guardian custody ☐Minor in state custody

Parents/Caregiver's Names: _____________________________________

Address: ____

City/State:_____________________, Fl. Zip:___________

Home Phone:______________________________ Cell Phone/Other_________________

Email:____

School/Daycare Info:____ Grade:_____________

Does the child have an IEP/504 Plan? ☐yes ☐no

Caregiver's primary language:______________ Bilingual needed? ☐yes ☐no Deaf/Hard of Hearing? ☐yes ☐no

OPEN SERVICES/PROVIDER CONTACT

☐ No current services

☐ Name/Agency:____ Phone:______________________

☐ Name/Agency:____ Phone:______________________

FUNDING INFORMATION

☐Medicaid #:____________________________ ☐Other Insurance: ____

ID #:____ Group #:________________________

AREA OF CONCERN

____

____

Supervisor notes:

Date Assigned: Disability Navigator Name:
Disability Navigator Sector/Zone:

"This program is funded in full or part by Orange County, Florida"