Disability Navigator Program
Phone: (407) 629-7881
Fax: (407) 629-4754
Email: mortiz@fl.easterseals.com

REFERRAL FORM

REFERRAL SOURCE INFORMATION

Referral By:_____ **Date:**_____

Phone:_____ **Fax:**_____ **Email:**_____

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 ☐ Young Adult

Parents/Caregiver's Names:_____

Address:_____ **City/State:**_____ **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

OPEN SERVICES/PROVIDER CONTACT

☐ **No Current Services**

☐ **Name/Agency:**_____ **Phone:**_____

☐ **Name/Agency:**_____ **Phone:**_____

☐ **Name/Agency:**_____ **Phone:**_____

FUNDING INFORMATION

☐**Medicaid #:**_____ ☐**Other Insurance:**_____

ID #:_____ **Group #:**_____

AREA OF CONCERN

_____

_____

Supervisor Notes:

Date Assigned: **Disability Navigator Name:**

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