

# Referral Form

Phone: 1.844.NTX-KIDS (1.844.689.5437)  
 Email: [Referral@HelpMeGrowNorthTexas.org](mailto:Referral@HelpMeGrowNorthTexas.org)  
 Fax: 817-810-3980

Help Me Grow North Texas is partnering with families in support of their child's healthy development with:

- Free developmental screening for every child
- Help in answering pregnancy, parenting & child development questions
- Connecting to community resources and supports

<b>Provider Information</b>	<b>Name of Organization or Clinic:</b>		
	<b>Contact Person:</b>		
	Street:	City:	Zip Code:
	Phone:	Fax:	Email:
	<b>This family is receiving services from our office:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Have you completed an ASQ on this child?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No   Results: ASQ-3 _____ ASQ-SE _____		
	<b>Parent or Guardian Name (s):</b>		
Street:		City:	Zip Code:
Phone:		Email:	
<b>Ethnic Identity:</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Unknown/Declined		<b>Racial Identity:</b> <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
<b>Best time to contact:</b> <input type="checkbox"/> Between _____ & _____ <input type="checkbox"/> After 5pm <input type="checkbox"/> Anytime <b>Best form of contact:</b> <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Text <b>Please contact me in:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:			
<input type="checkbox"/> <b>I am currently pregnant</b> <b>Due Date:</b>			
<b>Child Name:</b>			<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth:		Premature? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, # of weeks early:	
Concerns:			
<input type="checkbox"/> <b>Ask me about my other children when you contact me.</b>			

**Please fax or email this from to: 817-810-3980      Email: [Referral@HelpMeGrowNorthTexas.org](mailto:Referral@HelpMeGrowNorthTexas.org)**

We promote the early identification of developmental, behavioral or educational concerns and link families to community-based services and supports at no cost to parents and caregivers.

**For more information call or visit our website**

[www.HelpMeGrowNorthTexas.org](http://www.HelpMeGrowNorthTexas.org)

ID#: \_\_\_\_\_

Child's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

## Reciprocal Consent to Release and Share Information

I, \_\_\_\_\_, am the

Name of Parent / Legal Guardian

(check one):

Parent

Surrogate Parent

Legal Guardian of

\_\_\_\_\_  
Child's Name

DOB: \_\_\_\_\_, and

Child's Date of Birth

- I hereby attest that I am the custodial parent or authorized legal representative and have the authority to provide and consent to the release of this information.
- I hereby consent and agree to **participate in the Help Me Grow North Texas program**. I understand that the information gathered is part of the screening process and I will be referred for services to the service provider listed below, based upon information I provide.
- I understand and authorize that any and all information that I have provided to Help Me Grow North Texas will be shared with the service provider listed below through an online platform called **FINDconnect**, a centralized access system designed to assist families and professionals in connecting children to appropriate community-based programs and services.
- I hereby authorize Help Me Grow North Texas and the service provider listed below:

\_\_\_\_\_  
Name of Service Provider (Agency, Organization, or Individual)

to **reciprocally release and share any records or information** (in writing, verbal, or electronic format) pertinent to evaluate and meet the developmental, educational, medical, clinical, rehabilitative, social, and/or therapeutic needs of my family and child named on this consent.

- After a referral is made, I understand that the above-named service provider will contact me directly. Help Me Grow North Texas receives no financial benefit or gain as a result of any referral; referrals do not constitute an endorsement.
- I understand that this consent is voluntary and is effective for a period up to twelve (12) months from the date of my signature below. I also understand that I may revoke this authorization at any time; however, the revocation does not apply to any action that has taken place prior to the date I revoked this authorization.
- I understand that personally identifiable information collected as a result of this consent is confidential and shall be maintained in records that are subject to the provisions of the Family Educational Rights and Privacy Act (FERPA), and, as such, is available for my review and may be reproduced or corrected upon my request.

\_\_\_\_\_  
▶ Signature of Parent/Legal Representative\_\_\_\_\_  
Printed Name\_\_\_\_\_  
Date