Referral for Services

THOMPSON
Strengthening Children, Families & Communities
IMPACT
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smart start™

Client Information

Childs Name:_____DOB:_____

Parent/Guardian Name:_____

Home Address:_____

City:_____Zip:_____ County:_____

Home# ( )_____Alternate#( )_____

Email:_____

Child Care Information

Center Name:_____

Address:_____

City:_____Zip:_____(704)_____

Director:_____ Teacher:_____

Days and hours attended_____

Enrollment Date: _____ Licensed Center: Yes ___ No ___

Area of Concern (check all that apply):

Specialized Therapy, *Mecklenburg only*:
☐ __Speech __Occupational __Physical
Date of last evaluation:_____
☐ Transitioned out of CDSA/Does not meet eligibility of CDSA
☐ Does not meet eligibility criteria of E.C. public school services
☐ Other: _____

Behavioral Concerns:
Please describe behavior:

Physician Information

Physician Practice:_____

Physician Name:_____

Phone#:( )_____Fax#:( )_____

Address:_____

Consent For Treatment

☐ **I give permission** for my son /daughter (circle)
_____ to receive an evaluation and treatment as needed to meet the individual needs of my child.

Signed: _____ **Date:**_____

Release of Information

_____I do ____ I do not
Give permission to Thompson IMPACT to release information in my child's records **at my request** to Pediatrician, Local Public Schools or CDSA. This information may include Screening Results, Evaluation Reports, Visit Notes, Treatment Plans, and Discharges Summaries. This release will expire 1 year from the date of my signature.

Signed:_____**Date:**_____

Referral Name:_____
Organization:_____
Phone:_____Fax:_____

***Please mail, email or fax completed referrals to Thompson Attn: IMPACT**

OFFICE USE ONLY:
_____Entered _____Parent contacted
___BIS _____Provider