

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF HUMAN SERVICES

Office of Early Childhood Development  
DC Early Intervention Program



EVALUATION REFERRAL TO PART C

Dear DC Early Intervention Program:

The child named below has come to the attention of the \_\_\_\_\_  
Evaluation Center/Program

This child is suspected of having a developmental delay or disability and is being referred for further evaluation and assessment. If additional information is required, please contact

\_\_\_\_\_, at \_\_\_\_\_  
Referral Source Phone

Sincerely,

\_\_\_\_\_

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

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ (H) \_\_\_\_\_ (W)

Health Insurance \_\_\_\_\_ ID# \_\_\_\_\_

Referred By \_\_\_\_\_

Date of Referral \_\_\_\_\_

Area(s) of Concern \_\_\_\_\_

\_\_\_\_\_  
(Parent Signature Indicating Consent To Release Information) Date

For DC EIP Office Use Only

Date Received \_\_\_\_\_ Approved By \_\_\_\_\_ evalref to-9/01