

Date ICP Received

Referral : _____



Indian Children's Program (ICP) Referral Form

ARIZONA

Institute for Human Development

Northern Arizona University

P O Box 5630

Flagstaff, Arizona 86011-5630

(928) 523-8026

FAX (928) 523-4909

Name of child: _____

Date of birth: _____ Age: ____ Male Female School or Preschool: _____

Tribal census number: _____ IHS Chart number: _____

Parents/Guardian (circle one): _____

Mailing address: __ Mother's __ Father's __ Both: _____

Location of home: _____

Phone number(s): (Mother's) _____ (Father's) _____ (Other) _____

Person making the referral: _____ Address: _____

Phone: _____ Fax: _____

If referral from DDD -The SC has explored all other options for services (DDD vendors, IHS, school, etc.) Yes No

Is the family aware of the referral? Yes No

Will an interpreter be needed? Yes-Language _____ No

Reason for referral: (Check all that apply)

Delays in problem solving/thinking

Difficulty with academics/learning

Difficulty with speech & language

Difficulty with adaptive skills (eating, dressing etc)

Difficulty with behavior

Difficulty with social/emotional skills

Difficulty with motor skills

Suspect Autism

Other concerns _____

Services requested: (Check all that apply)

Evaluation needed

Determine eligibility/present levels of performance for program planning

Consult with family/provider

Therapy services

TA/training for provider

Other: _____

Reason ICP is needed: (Check all that apply)

Would like to know what services this child may be receiving Need specialized expertise

No other services available Local service agencies overloaded Other _____

Comments or Concerns: _____



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Flagstaff, AZ 86011
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AUTHORIZATION TO DISCLOSE CONFIDENTIAL EDUCATIONAL RECORDS

Child's Full Name: _____

Child's Date of Birth: _____

Parents: _____

Date of Request: _____

I give my permission for the **Educational School or Program**, _____
to disclose my child's educational records to:

Indian Children's Program
Northern Arizona University
P.O. Box 5630
Flagstaff, AZ 86011

I specifically authorize the information checked below to be disclosed to the above listed program.

- _____ Psychoeducational evaluations
- _____ Therapists' evaluations and progress notes
- _____ Teachers' evaluations and progress notes
- _____ Mental health/Behavior evaluations and progress notes
- _____ Hearing and vision screenings/evaluations
- _____ Other: _____

This disclosure is being made at my request, and I choose not to state the reason for this disclosure.

I specifically authorize the disclosure of protected educational information for the following purpose(s):

By signing this Authorization, I understand that:

- I may refuse to sign this authorization, and my refusal will not affect my eligibility for services or benefits.
- I may inspect or copy any information to be disclosed under this authorization.
- I may have a copy of this document.
- A copy of this authorization shall be as valid as the original.

Signature of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____

Date of Authorization: _____ Date Authorization will Expire: _____

Indian Children's Program is not able to pay copy costs for records.