WHATCOM takingaction for Children and Youth with Special Health Care Needs (CYSHCN)

opportunity council

SEAS Referral Form

For children & youth with special healthcare needs - Serving ages Birth through 21
HIPAA/Confidential Fax: 360.676.6729

SEAS
Single Entry Access to Services
phone: 360.715.7485
fax: 360.676.6729

Section 1 - Anyone can fax a referral to SEAS with a parent's knowledge and consent.
SEAS cannot call a family unless statement below is checked and initialed by referrer.
☐ **Parents have consented to this referral to SEAS** _____ (Referrer's initials)

Date:	Referrer:	Phone: Fax:	Child's Primary Care Provider (PCP):
Child's Name: Sex: ☐M ☐F	DOB:	Parent/Guardian Name(s):	
Home Address:	Phone:	Alternative Phone:	
City: Zip:	Email Address:		

Will this family need an interpreter? ☐ Yes ☐ No If yes, what language?

Section 2 – Use section below to describe concerns and request navigation.
Please attach medical notes, case notes, and/or additional information.

I have concerns about the child's: ☐ Development ☐ Autism Spectrum Disorder (ASD)
☐ Mental/Behavioral Health ☐ Other Neurodevelopmental Disorder:
☐ Other:

Has this child already received an evaluation for the above concern(s)? ☐ Yes ☐ No

Please Navigate to:
☐ Early Support for Infants and Toddlers
(AKA: ESIT, Early Intervention, Birth to 3. 0-3rd birthday)
☐ School District for Screening/Eval **(3 to 21)**
☐ GIDES Midlevel Evaluation*
☐ Outpatient Specialty Therapy Clinic*
☐ Mental/Behavioral Health Resources
☐ Other:

Section 3 - *Anyone can refer to SEAS, but GIDES and Clinical Specialty Therapies (below) **require a referral and signature from a Primary Care Provider (doctor/nurse practitioner).**
Call SEAS at (360) 715-6485 if you have any questions about these types of referrals.

GIDES, or General Interdisciplinary Developmental Evaluation System, is a program to evaluate for conditions such as neurodevelopmental disorders, global delays, ASD, etc. *not mental health*.

Clinic-based outpatient specialty therapy refers to therapies such as speech and OT provided outside of school district services or ESIT.

To refer to GIDES or a clinic, a PCP/Doctor must sign and date this box here. →

☐ **Navigate to GIDES midlevel evaluation, including referral to pediatric neurologist if needed.**

Diagnosis_____ **Code**_____

☐ **Navigate to clinic-based outpatient specialty therapy services.**

Diagnosis_____ **Code**_____
Therapies needed (Underline Priority):
☐ **Speech Therapy** ☐ **Feeding/Oral-Motor**
☐ **Swallowing Study—VFSS**
☐ **Occupational Therapy** ☐ **Physical Therapy**
☐ **Assessment Only**
☐ **Assess and treat for:** ☐ **6 months** ☐ **12 months**

***PCP Signature**_____ **Date**_____
☐ I have included the most recent WCC/chart notes, and the Ages and Stages Questionnaire (ASQ) or the age equivalent, the Modified Checklist for Autism in Toddlers (M-CHAT) or the equivalent.

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OPTIONAL PAGE: Additional Information to Attach to SEAS Fax Referral Form

Child's Name: _____ DOB: _____

Additional Information:

Referrer's Name: _____

Referrer's Phone: _____