



Referral for Services



c/o Thompson Child & Family Focus, Clanton Road Campus, 1645 Clanton Road, Charlotte, NC 28208 – 704.817.1607 - Fax: 704.332-7725

CLIENT INFORMATION

Child's Name:
 First: _____ Last: _____
 DOB: _____
 Parent/Guardian Name:
 First: _____ Last: _____
 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:
 Speech Occupational Physical
 Date of last evaluation: _____
 Transitioned out of CDSA/Does not meet eligibility of CDSA
 Does not meet eligibility criteria of CMS
 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 (child's name) _____ 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 the Smart Start Polliwog Project to release information in my child's records **at my request** to Pediatrician, Charlotte Mecklenburg Schools or Carlton Watkins Center. 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: _____
 Email: _____

*Please mail or fax completed referrals to Thompson Child and Family Focus, Attention Shonta Smith. Any questions, please call (704) 817-1607 or email ssmith@thompsoncff.org