

**Cabarrus Care Team
Referral Form**

Date of Referral _____

Child's Name _____ Date of Birth _____

Child Care Center _____ Teacher(s) _____ Phone # _____

Parent's Name _____ Phone # _____

Home address _____

***Doy mi permiso para que los resultados de la evaluación se compartan con el Programa de los Niños Excepcionales Preescolares de las Escuelas del Condado de Cabarrus.
(I give my permission for the results of the screening to be shared with Cabarrus Schools/Kannapolis City Preschool Exceptional Children's Program).***

Firma de Padre (Parent Signature) _____ Date (Fecha) _____

Vision Pass or Fail Date _____
Snellen Chart or Welch Allyn vision screener
{Please circle instrument used}

Hearing Pass or Fail Date _____
Audiometer or OAE or Welch Allyn Audio Path
{Please circle instrument used}

DIAL 4 Completed on: _____

Results: Motor Score: _____
Concepts Score: _____
Language Score: _____

Notes/Comments:

**Please include a copy of Health Assessment with this Referral Form*

Contact Elizabeth Albright or Jamie Clark at cabarruscountycareteam@gmail.com for questions.

Child Care Center Representative

Date