Hillsborough County
Interagency Referral Alert

Date _____

❑ Male

Child's Legal Name_____ ❑ Female DOB _____

Physical Address_____Telephone # (____) _____

Mailing Address *(if different)* _____Other Phone # (____) _____

Mother's Legal Name _____ Father's Legal Name _____

Guardian _____

English packet _____ **Spanish packet** ____

Major Concerns for Referral _____

_____

_____

_____

Is the child in childcare or school program? ❑ Yes ❑ No If yes, where? *(name, address, phone)*

_____

Other Services/Agencies & Contact Person

_____

_____

_____

_____

_____

Referral Source/Contact Person

Name_____

Address_____

Telephone (_____) _____

FAX (_____) _____

Agency_____

Consent Statement for Referral Alert

I agree to this Referral Alert being sent to the following agency(ies) for the purpose of obtaining help.
This consent is valid for 90 days from the date of signature.

_____ _____
Parent/Guardian Signature Date

Agency	*Contact*	*Telephone #*

Feedback to Referring Agency:

_____ _____ _____
Signature *Date* *Telephone*

FDLRS 07/2013. Fax Referral Alert to Child Find 813-837-7719 or email amanda.prive@sdhc.k12.fl.us (Photocopy as Needed)

School District of Hillsborough County • Department of Exceptional Student Education • Florida Diagnostic & Learning Resources System (FDLRS)
A Local interagency Community Collaboration Project and a FDLRS/Hillsborough Supported Activity 813-837-7777.