



The Wave of the Future
Winnebago County

Department of Human Services

BIRTH to 3 PROGRAM FAX REFERRAL FORM

Date of Referral: _____

_____ **COMMUNITY REFERRAL**

_____ **PHYSICIAN REFERRAL**

Child's Name (MI) _____ **DOB** ____/____/____ **M / F**

Parents/Guardian _____ **Phone #** _____

Address (Child must reside in Winnebago County) _____

Work or Cell Phone # _____ **Best time to call** _____

Referral Source name _____ **Title** _____ **Phone #** _____

Referral Source agency _____

Child's Physician/Clinic _____ **Phone #** _____

Parents aware of intent to refer **Yes** **No**

Referral information: check all that apply

Diagnosed Condition _____

Sibling of a Child currently receiving B-3 services

B-3 transfer from another County _____ (county name)

Feeding concerns or problems

Non-English Speaking **Interpreter needed** **Yes** **No**

Daycare referral (name and contact) _____

Speech concerns: **Ear infections** **Yes** **No** **# many**, **Hearing evaluation** **Yes** **No**

Results of Hearing Evaluation _____, **PE Tubes** **Yes** **No**

Motor or Physical concerns (rolling, sitting, crawling, walking)_specify: _____

Referral from an agency that does developmental screenings (name of agency) _____

Results of screening _____

Referral from a Hospital or Neonatal Intensive Care (NICU)

Name of Hospital or NICU _____

Foreign Adoption _____ **date child arrived home** ____/____/____

ADDITIONAL INFORMATION

Phone Referrals– Oshkosh Area: 920-236-4615 Neenah/Menasha: 920-727-2882 ext 4615

PLEASE FAX COMPLETED FORMS TO: FAX – 920-303-3037 --DHS Access Intake
(Feel free to make additional copies for future use)

Original Form can also be found on Early Intervention Services Website: **go to www.eisb23.org** Click on Fax Referral Form.