Consent / Decline for SoonerStart Referral

Child's Name: _____ Date of Birth: _____

Parent Name: _____ Phone: _____

Address: _____

Center/Room #: _____ Phone: _____

ASQ-3: _____ Date: _____

ASQ-SE2: _____ Date: _____

Vision: _____ Date: _____

Hearing: _____ Date: _____

Other: _____ Date: _____

*Initial developmental screening indicates need for further evaluation. We recommend a referral to SoonerStart for the following developmental concerns:

____ Communication (speech/language/articulation)

____ Gross Motor (large muscle tasks)

____ Fine Motor (finger/hand grasp)

____ Cognitive/ Problem Solving

____ Personal-Social (peer relationships/behavior)

____ Vision/Hearing

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*Please initial next to the applicable statement and sign/date below:

_____ I give my consent to refer my child for testing and evaluation with SoonerStart.

_____ I DO NOT give consent for referral to SoonerStart.

Parent/Guardian: _____ Date: _____

Staff Signature: _____ Date:

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