

**WAUKESHA COUNTY BIRTH-TO-THREE REFERRAL FORM (Waukesha County Residents Only)**

Date of Referral: \_\_\_\_\_ Referral Source: \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Additional Phone: \_\_\_\_\_ Best to call? \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

DX/Areas of Concern: \_\_\_\_\_ Interpreter Services Needed   
may we email you?  yes

Previous B-3 Services Received by Family:  NO  YES email \_\_\_\_\_  
Will make copies of insurance cards? \_\_\_\_\_

Insurance Carrier Name: \_\_\_\_\_

Availability: \_\_\_\_\_ School District: \_\_\_\_\_

Smoker in Home:  NO  YES Cats:  NO  YES Dogs:  NO  YES CPS Referral: Yes  No

Referral Taker: \_\_\_\_\_

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Directions: \_\_\_\_\_

Notes/Log: \_\_\_\_\_

Assigned Staff: SVC \_\_\_\_\_ Date: \_\_\_\_\_

ST Eval \_\_\_\_\_ Date: \_\_\_\_\_ Treat \_\_\_\_\_ Date: \_\_\_\_\_

PT Eval \_\_\_\_\_ Date: \_\_\_\_\_ Treat \_\_\_\_\_ Date: \_\_\_\_\_

OT Eval \_\_\_\_\_ Date: \_\_\_\_\_ Treat \_\_\_\_\_ Date: \_\_\_\_\_

EDU Eval \_\_\_\_\_ Date: \_\_\_\_\_ Treat \_\_\_\_\_ Date: \_\_\_\_\_

Attached: IFSP \_\_\_\_\_ INS \_\_\_\_\_ DR ORDER \_\_\_\_\_ IFSP DUE DATE \_\_\_\_\_

Ref. Routing: KW \_\_\_\_\_ SVC \_\_\_\_\_