Do not alter Essex County Forms. They have been designed to meet State and Federal requirements.

HEALTH DEPARTMENT
Children's Services Unit

ESSEX COUNTY CPSE SERVICES REFERRAL FORM

School District:_____Date:_____

Referral to:_____

Child's Name:_____ DOB:_____

Parents Name:_____

Parents Phone:

Address:_____

City, State, Zip:_____

IEP Dates:_____ Change in IEP Dates:_____

SERVICES	FREQUENCY AND DURATION	AGENCY / INDEPENDENT	PROVIDERS NAME	LOCATION OF SERVICES
SEIT				
SPEECH				
OT				
PT				
COUNSELING				
1:1 AIDE				
CENTERBASE				
TVI				
O & M				
OTHER				

Upon Completion please fax to: Essex County Attn. Kelly at 873-3863 or Denise Proulx 561-5624

☐ Accept

☐ Decline Signature Signature Date