Miami-Dade County
Community Action and Human Services Department
Head Start/Early Head Start Division

External Referral /Follow-up Form

Date of referral _____

Child's Name:	Last:	First:	Date of Birth:
Parent(s) Name:		Address:	
Telephone #	Home:	City:	Zip:
	Work:	Center Name:	
	Cell:		

PART I REFERRER

FROM:	Name of Referrer	TO:	Name of Recipient
☐ Center Director/Administrator		☐ Physician/ Health Provider	
☐ Social Worker		☐ Dental Provider	
☐ Health Services		☐ Mental Health Provider	
☐ Disability Services		☐ Disability Provider	
☐ Mental Health Services		☐ WIC	
☐ Teacher		☐ Healthy Start	
☐ Nutrition Services		☐ Nutrition Provider	

PART II REFERRAL

Description of Problem

☐	Absentee	☐	Health/ Oral Health/ Nutrition Related	☐	Mental Health/ Disability Related	☐	Observation Needed	☐	Other

Describe the problem (be specific):

Additional comments:

PART III FOLLOW-UP

Status of Referral

☐	Being Handled	☐	Additional Follow-up Needed	☐	Problem Resolved

Describe action taken (be specific):

Please return this form to sender with status	Follow-up completed by:	Date:	

ORIGINAL: CHILD'S FILE COPY: TO REFERRER

Copy of follow-up report must be add to child's file after completion.