Developmental Educational Assistance Program (DEAP)
2200 Box Elder, Suite 151 Miles City, MT 59301
Phone (406)-234-6034 Or 800-224-6034 Facsimile (406)-234-7018

EVALUATION & DIAGNOSIS PROGRAM REFERRAL FORM

REFERRAL DATE: _____ SCREENING DATE: _____

CHILD'S NAME: _____
LAST FIRST M.I.

BIRTH DATE: _____ RACE: _____

CHILD'S SOCIAL SECURITY NUMBER: _____

INSURANCE/MEDICAID NUMBER: _____

PARENT/GUARDIAN: _____
☐ BIOLOGICAL ☐ ADOPTIVE ☐ FOSTER ☐ OTHER

OCCUPATION: _____

MAILING ADDRESS: _____
street or box number city state zip

PHONE: (____) ____- ____ COUNTY: _____

REFERRAL SOURCE: _____

MAILING ADDRESS: _____
street or box number city state zip

PHONE: (____) ____- ____

HAVE PARENTS BEEN NOTIFIED OF REFERRAL? ☐ YES ☐ NO

1. REASON FOR REFERRAL / 2. DESCRIPTION OF PROBLEM / 3. GUARDIAN'S QUESTION/CONCERNS: _____

SERVICES RECEIVED: _____
NAME OF PERSON TAKING REFERRAL: _____
FAMILY SUPPORT SPECIALIST ASSIGNED: _____

Notes: