State of Illinois
Department of Human Services - Migrant & Seasonl Head Start

Diagnostic Referral and Reporting Form

Attention Diagnostician:

In order to ensure that the child qualifies for Head Start Disabilities Services, it is necessary that you supply some information. This information will be held confidential.

To be filled before referral by the Head Start agency:

Referral date: ______________________________

Name of the child: ______________________________

Age and date of birth: ______________________________

Parent's name: ______________________________

Address and telephone number: ______________________________

Head Start information:

Name of the center and address: ______________________________

Contact person: ______________________________

Reason for referral:

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1. Eligibility Criteria:

According to my professional judgment, and with the instruments used (please list, if any):

______________________ ______________________

______________________ ______________________

this child qualifies for disabilities services and meets the Head Start Disabilities Criteria for the following conditions:
(NOTE: if the child has multiple disabilities, please number the primary condition #1 and the secondary #2, etc.)

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_______ Health Impairment

_______ Emotional/Behavior Disorders

_______ Speech/Language Impairments

_______ Mental Retardation

_______ Hearing Impairment

_______ Orthopedic Impairment

_______ Visual Impairment

_______ Learning Disabilities

_______ Autism

_______ Traumatic Brain Injury

_______ Other Impairments

Signature of Diagnostician: ____________________

License #: ____________________

Address and telephone number: ____________________

Date: ____________________