WHATCOM takingaction
for Children and Youth with Special Health Care Needs (CYSHCN)

FAX TO: SEAS

Rev. 07-23-15

Single Entry Access to Services
phone: 360.715.7485
fax: 360.676.6729 (HIPAA/Confidential Fax)

REMINDER: Please attach ASQ and/or other screenings with SEAS referral.

☐ **Parents have agreed to this referral to SEAS** _____ (Provider's initials)

☐ Interpreter Needed

Today's Date _____ Language: _____

Referring Provider _____ Phone_____ Fax _____

(Please Print)

Child's Name _____ ☐M ☐F DOB _____

Parent/Guardian Name(s) _____ Home Phone_____

Address _____ City _____ Zip _____ Cell _____

Conditions/diagnoses/concerns:

SEAS, please navigate to:

☐ **Birth to Three Early Support for Infants and Toddlers (ESIT)** ☐ Family Support
☐ Developmental Evaluation ☐ Resource Information ☐ Other

For GIDES/ASD Evaluation and/or PHMG Children's Therapy Services, the pertinent section(s) below *must* be completed and *must* include Primary Care Provider's signature and date.

☐ **GIDES Autism Spectrum Disorder (ASD) evaluation from Seema Afridi, MD, PHMG/Neurology Associates, which includes coordination services from The Arc of Whatcom County.**

ASQ and/or M-CHAT (or equivalent) must be attached and the following must be completed, *including PCP's signature and date:*

Diagnosis _____Code _____ Precautions _____

PCP Signature _____ Date _____

☐ **PeaceHealth Medical Group Children's Therapy Services**

The following must be completed, *including PCP's signature and date:*

Diagnosis _____ Code _____ Precautions _____

☐Speech ☐Feeding/Oral-Motor ☐Swallowing Study—VFSS ☐OT ☐PT ☐Orthotics

☐Assessment Only ☐Assess and treat for: ☐6 months ☐12 months

PCP Signature _____ Date _____

RESPONSE FROM SEAS NAVIGATOR TO REFERRING PROVIDER

Child's Name _____ DOB _____

☐ Family did not respond to phone or letter ☐ Family declined services

☐ Family has been referred to: _____ ☐ See attached

Date _____ SEAS Navigator _____ Phone _____