

**SCRIPT FOR PERSON RECEIVING EDN REFERRAL CALLS**

Our Plan: >One laminated form and several forms on regular paper in a yellow folder with EDN logo & sticker with phone number to call for more forms on the front

>Distribute to school secretaries along with EDN information (either at their yearly meeting or individually at their school)

Form:

(EDN logo on top)

School District \_\_\_\_\_

Today's Date \_\_\_\_\_

The Early Development Network is a program that provides support to families of children birth to three when parents have a question or concern about their child's development. One of our Early Intervention Services Coordinators, Rose Petersen or Lori Harring, will contact you within the next two days. I'll take some contact information that I will pass on to the Services Coordinator so that she can call you. She'll gather the necessary information for your child's evaluation and share information about the program with you. This program is at no cost to you.

Parent's Name \_\_\_\_\_

Address \_\_\_\_\_

Phone number to contact you \_\_\_\_\_

Child's Name \_\_\_\_\_

Child's Birthdate \_\_\_\_\_

Best time to contact you \_\_\_\_\_

Thank you for calling.

\*\*\*\*\*

Please forward immediately to:

FAX: ESU 4 402-274-4356 Attn: Early Development Network

Or

EMAIL: [rpetersen@esu4.net](mailto:rpetersen@esu4.net) or [lharring@esu4.net](mailto:lharring@esu4.net)

**GOOGLE DOC SHARED WITH DISTRICTS**

**Early Development Network – Referral**

If a parent of a child, birth through 2 years of age, calls with concerns about their child's development, they may refer their child to the Early Development Network. ESU 4 provides Services Coordination for all districts in the ESU 4 area. Rose Petersen and/or Lori Haring will contact the family within 2 days of receiving this referral. Please email this form immediately to [rpetersen@esu4.net](mailto:rpetersen@esu4.net) or [lharring@esu4.net](mailto:lharring@esu4.net). Thank you.  
(\* indicates required field)

Name of parent(s)\*

Name of child \*

Child's date of birth \*

Address (Street; Town; Zip Code)\*

Phone Number(s); indicate the preferred number to call \*

Name of person making the referral \*

Name of person reporting the referral \*

Concern/reason for referral \*

Who is referring this child?\*

- Parent
- Family member (grandparent, aunt/uncle, etc.)
- Medical (doctor, nurse, Clinic, etc.)
- DHHS (Health & Human Services)
- Other agency \_\_\_\_\_
- Other \_\_\_\_\_

Notes/Other Information: