Child's Name: _____
Date of Birth: _____

Florida Diagnostic & Learning Resources System – South (FDLRS-South)
Child Find Referral Packet
6521 S.W. 62nd Avenue, South Miami, Florida 33143
Main Office - Phone: (305) 274-3501

Dear Parent/Guardian,

Your child has been referred to FDLRS-South for a screening to determine if there is a concern of a suspected developmental delay or speech/language delay. If warranted, your child will be referred to Miami-Dade County Public Schools (M-DCPS) for further screening/evaluation. Below is a list of the documents that need to be completed and submitted prior to the scheduled screening.

Please complete and provide the following list of documents to FDLRS-South. The documents with an asterisk are required to process the case. Check the boxes to the left of the listed documents if you will be submitting that item as part of the referral.

- ☐ **Copy of Child's Birth Certificate *** *(If not available, passport or certificate of baptism are acceptable)*
- ☐ **Custody Documentation*** *(Required only if child is NOT in the custody of a biological parent)*
- ☐ **Lead Sheet (attached)**
- ☐ **FDLRS- South Child Find Parent Observation Form (attached)**
- ☐ **Summary of Student Psychosocial History (attached)**
- ☐ **Home Language Survey** (FM # 5196) **(attached)**
- ☐ **Signed Consent Form for Mutual Exchange of Information** (FM # 2128) **(attached)**
- ☐ **Observation of Prekindergarten Student Behaviors** (FM # 4140 - *For teacher/therapist to complete if child attends an early childhood center or receives therapy)* **(attached)**
- ☐ **M-DCPS Hearing and Ear Health History form (attached)**

Additional Important Child Find Referral Documents:
Please submit copies of the following records, if available.

- ☐ **Relevant Medical Records (e. g., neurological, genetics, etc.)**
- ☐ **Hearing/ Audiological Report (if done within the last year)**
- ☐ **Vision Report (if done within the last year)**
- ☐ **Psychological Evaluation Report**
- ☐ **Speech/Language Evaluation Report**
- ☐ **Behavioral Evaluation Report**

Documents can be submitted to FDLRS- South using one of the following methods:

- Email: FDLRS-South@dadeschools.net
- U.S. Mail or Drop-off at: 6521 S.W. 62nd Avenue, Room 1, Miami, Florida 33143

If you need assistance in completing these forms or if you have any questions, please call us at 305-274-3501.

Sincerely,
The Child Find Team at FDLRS-South

Child Find Office Use Only
Complete the following if referral is made by an Agency or School:
Contact Person: _____
Agency/School: _____
Phone: _____ **Fax:** _____

FLORIDA DIAGNOSTIC & LEARNING RESOURCES SYSTEM - SOUTH
LEAD SHEET

Pick a service location for the evaluation:

O Main Office	O Central	O North	O South
JRE Lee Educational Center 6521 SW 62nd Avenue South Miami , FL 33143	Thena C. Crowder Early Childhood Diagnostic and Special Education Center 757 NW 66th Street Miami, FL 33150	Robert Renick Educational Center 2201 NW 207 Street Miami Gardens, FL 33056	Center for International Education 900 NE 23 Avenue Homestead, FL 33033

Date: _____ Referred by (Name) _____

Referral Source Phone: _____ Email: _____

Child's Name: _____ DOB: _____ Age: _____

Sex: O M O F Birthplace: _____ Race: _____

Primary Language: _____ Other language spoken at home: _____

Attending Preschool: O Y O N If yes, name of facility: _____

O Parent O Foster O Guardian name: _____

E-mail: _____ Cell: _____

Home Address: _____

City: _____ Zip Code: _____ Alternate Phone Number: _____

Alternate Contact Name/Relationship to child: _____ Number: _____

Reason for Referral (Mark all that apply)

O **Speech** (hard to understand, talking is not clear)

O **Expressive Language** (limited spoken vocabulary)

O **Receptive Language** (doesn't seem to understand, difficulty following directions)

O **Social-Emotional** (interaction with others, social skills)

O **Cognition** (seems behind, difficulty retaining information)

O **Behavior** (aggressive, harms self or others, inattentive, active)

O **Fine Motor** (holding, drawing, grasping, picking up small objects)

O **Gross Motor** (clumsy, falls a lot, poor coordination or balance)

O **Self-Help** (independent functioning, toileting, feeding, dressing)

O **Vision Difficulties**

O **Hearing Difficulties**

Medical Diagnosis: O Y O N Specify: _____

Receiving therapies: O Speech/Language O Occupational O Physical O Behavior Location: _____

Comments: _____

FOR CHILD FIND USE ONLY:

Language Code: _____ K- _____ Information Rec'd by: _____

Homeschool: _____ Entered in CHRIS by (initials) _____

Screening /Evaluation Appointment: _____ DB# _____

Email the completed form to FDLRS-South@dadeschools.net
Contact: FDLRS-South at 305-274-3501

Rev. 6/8/22

Florida Diagnostic & Learning Resources System-South (FDLRS-South)
Child Find Parent Observation Form

Child's Name: _____ **Birthdate:** _____ **Age:** _____

Person Completing this Form: _____ **Relation to Child:** _____ **Date:** _____

Directions: Please check any behaviors that are a concern (leave boxes blank if there are no concerns).

1. Attending Behaviors

- ☐ Easily distracted
- ☐ Overly active
- ☐ Short attention span
- ☐ Difficulty remembering things
- ☐ Impulsive
- ☐ Needs a lot of attention from adults

2. Disruptive Behaviors

- ☐ Physically aggressive (hits, pushes, bites, pinches)
- ☐ Hurts himself/herself intentionally
- ☐ Verbally abusive (yells, uses inappropriate language)

3. Social/Emotional Indicators

- ☐ Anxious/nervous
- ☐ Is easily frustrated
- ☐ Repeats behaviors over and over (rocking, pacing, spinning)
- ☐ Does not get along with other children
- ☐ Prefers to play alone
- ☐ Seems unhappy
- ☐ Has difficulty taking turns
- ☐ Plays with one toy over and over again for very long periods
- ☐ Has frequent temper tantrums
- ☐ Does not get along with adults
- ☐ Avoids interaction with other children
- ☐ Becomes upset easily
- ☐ Cries frequently
- ☐ Is overly fearful in new situations
- ☐ Does not engage in pretend play (feeding the baby, talking on the phone, etc.)

4. Speech/Language

- ☐ Does not follow simple directions
- ☐ Speech is not understood by others outside of the family
- ☐ Does not engage in conversation
- ☐ Still utilizes a pacifier on a regular basis
- ☐ Does not speak in 3 – 4 word sentences
- ☐ Stutters with sounds ("m, m, m, many"), repeats words or phrases, or gets "stuck" on words
- ☐ Has difficulty naming basic objects or people
- ☐ Voice sounds different from other children (raspy, nasal, hoarse, high pitched, too soft, too loud)
- ☐ Has difficulty understanding what is said to him/her

5. Motor Skills

- ☐ Appears clumsy or uncoordinated
- ☐ Has difficulty turning the pages of a cardboard book
- ☐ Frequently drops, spills, or knocks things over
- ☐ Has difficulty holding a bottle or cup by himself/herself
- ☐ Is unsteady when walking
- ☐ Has difficulty holding a thick crayon

6. Self-Help Skills

- ☐ Cannot feed himself/herself independently
- ☐ Has frequent toileting accidents during the day
- ☐ Needs assistance washing/drying hands

7. Sensory Issues

- ☐ Is a very picky eater
- ☐ Covers ears to loud noises
- ☐ Sensitive to wearing certain clothing (e.g., socks, shoes, clothing labels)
- ☐ Does not tolerate large crowds

8. Other

- ☐ Has difficulty with changes in routine
- ☐ Has frequent nightmares
- ☐ Frequently wets the bed
- ☐ Has difficulty learning simple rules
- ☐ Walks on tiptoes
- ☐ Does not respond to name when called
- ☐ Has unusual fears
- ☐ Has been asked to leave a preschool or daycare

Clear Form

MIAMI-DADE COUNTY PUBLIC SCHOOLS

CONSENT FORM FOR MUTUAL EXCHANGE OF INFORMATION

Date _____

Student's Name _____

Date of Birth _____ ID# _____

I hereby authorize the mutual exchange of records pertaining to my child or myself, _____ _____ , between the MIAMI-DADE COUNTY PUBLIC SCHOOLS and the following agencies (include all schools, physicians, psychologists, hospitals, clinics, etc., that have had significant contact with your child):

Name	**Address**

- The specific records to be disclosed pertain to: _____

- The purpose for making these records available is: _____

- **The receiving party will not disclose the information to any other party without signed consent.**

I certify that I am the parent or legal guardian of the child named above or that I am a student of majority age and have the authority to sign this release.

_____ _____
Name (print) Signature

_____
Address City, State Zip Code

Please return this form to: _____

_____

_____

_____

MIAMI-DADE COUNTY PUBLIC SCHOOLS

HOME LANGUAGE SURVEY

To Be Completed By Parent or Guardian

Student I.D. No. _____

Student Name _____ _____ _____
Last First Middle

Date of Birth ____/____/____ Grade_____ Parent Language _____ Student Language _____
Month Day Year

Date Entered U.S. School : ____/____/____ Ethnic Hispanic _____ (Y/N) (Check all that apply) Race: White ☐ Black ☐ Asian ☐
Month Day Year
American Indian ☐ Native Pacific Islander ☐

If the answer is "YES" to any of these questions, the student must be tested for English proficiency.	
1. Is a language other than English used in the home?	Yes ☐ No ☐
2. Did the student have a first language other than English?	Yes ☐ No ☐
3. Does the student most frequently speak a language other than English?	Yes ☐ No ☐

School _____ Date _____ Parent/Guardian Signature _____

ESCUELAS PUBLICAS DEL CONDADO DE MIAMI-DADE

ENCUESTA SOBRE EL IDIOMA HABLADO EN EL HOGAR

Debe ser completado por el/la padre/madre o tutor/a

No. De I.D. _____

Nombre del Estudiante _____ _____ _____
Apellido Nombre Inicial

Fecha de Nacimiento ____/____/____ Grado _____ Lengua Paterna _____ Idioma del Estudiante _____
Mes Día Año

Fecha de Entrada a la Escuela de los Estados Unidos: ____/____/____ Origen Etnico Hispano _____ (S/N) (Marque todo lo pertinente) Raza: Blanco ☐ Negro ☐
Mes Dia Año
Asiático ☐ Indígena de los EEUU ☐ Oriundo de las Islas del Pacífico ☐

Si responde "Sí" a alguna de estas preguntas, el estudiante debe tomar un examen para saber cual es su conocimiento del Inglés.	
1. ¿Usan en su casa algún otro idioma que no sea el Inglés?	Sí ☐ No ☐
2. ¿Tuvo el estudiante una lengua materna distinta al Inglés?	Sí ☐ No ☐
3. ¿Habla el estudiante frecuentemente otro idioma que no sea el Inglés?	Sí ☐ No ☐

Escuela _____ Fecha _____ Firma del Padre/Madre _____

MIAMI-DADE COUNTY PUBLIC SCHOOLS

SONDAJ SOU KI LANG TIMOUN NAN PALE

Pou paran oubyen moun ki responsab timoun nan ranpli

No. I.D. Elèv La _____

Non Elèv la _____ _____
Non fanmi Non

Dat Fèt li ____/____/____ Klas _____ Lang paran Yo _____ Lang Elèv La _____
Mwa Jou Ane

Dat ou Antre U.S. Lekòl: ____/____/____ Etnisite Espayòl _____ (W/N) (Tcheke tout sa ki aplike) Ras: Blan ☐ Nwa ☐ Azyatik ☐
Mwa Jou Ane
Amriken Endyen ☐ Natif II Pasifik ☐

Si repons lan se "WI" pou nenpòt nan kesyon anba yo, elèv la dwe pran yon tès Anglè.	
1. Eske yo sèvi ak yon lang ki pa Anglè lakay li?	Wi ☐ Non ☐
2. Eske elèv la te genyen yon premye lang anvan Anglè?	Wi ☐ Non ☐
3. Eske elèv la abitye pale yon lang ki pa Anglè?	Wi ☐ Non ☐

Lekòl _____ Dat _____ Siyati Paran _____

CC: FILE IN CUMULATIVE FOLDER
TO STAFF FOR TESTING

Florida Diagnostic & Learning Resources System-South
Summary of Student Psychosocial History

			Date:
Child Name:	**ID#**:	**D.O.B**:	**Age**:
Home School:	**Person Completing Form**:		
Respondent's Name/Relationship:	**Signature**:		
Home Address:	**Rent** ☐ **Own** ☐		
Telephone:	**Email**:		

FAMILY COMPOSITION

Name	Relationship	Lives with Child	Age	Occupation
	Mother	Yes / No		
	Father	Yes / No		
		Yes / No		
		Yes / No		
		Yes / No		

Child's place of birth: _____ Family's cultural origin: _____
Primary language spoken in the home: _____
Other languages child is exposed to: _____
Parents/Guardian's marital status: ☐ Single ☐ Married ☐ Separated/Divorced ☐ Widowed
Reason for referral/parent concerns:_____
_____

EDUCATIONAL HISTORY

Is the child currently attending school: Yes ☐ No ☐ If yes, Name/Date entered: _____
_____

Describe the student's current school experience, strengths and challenges: _____
_____

DEVELOPMENTAL HISTORY

Describe pregnancy and delivery of child, risk factors and/or difficulties: _____
_____
Gestation (months): _____ Birth Weight: _____ Postnatal Difficulties: _____
_____
Developmental Milestones (Age) Walked: _____ First Words: _____ Phrases: _____ Toilet Training: _____
Bedwetting: Yes ☐ No ☐ Explain:_____

MEDICAL/MENTAL HEALTH HISTORY

Describe history of illness, chronic health problems, syndromes: _____

_____

_____

Allergies to food, medication: _____

Injuries, surgeries, accidents, hospitalizations: Yes ☐ No ☐ If yes, date/explain: _____

_____

Current medications: _____

Eating problems: Yes ☐ No ☐ Difficulty sleeping: Yes ☐ No ☐ Speech/language problems: Yes ☐ No ☐
Vision impairment: Yes ☐ No ☐ Wears glasses: Yes ☐ No ☐ Hearing impairment: Yes ☐ No ☐

Has the child been seen by a neurologist, psychologist, or other professional? Yes ☐ No ☐ If yes, explain: _____

_____

_____

Has the child had any diagnostic testing such as MRI, EEG, etc.? Yes ☐ No ☐ If yes, explain: _____

_____

_____

Has the child received speech/language therapy? Yes ☐ No ☐ If yes, place of service and dates: _____

_____

Has the child received occupational therapy, physical therapy or behavioral therapy? Yes ☐ No ☐
If yes, place of service and dates: _____

_____

Family history of learning, medical, or mental health problems: _____

_____

INTERPERSONAL RELATIONSHIPS/BEHAVIOR

Describe the student's overall behavior at home: _____

_____

Discipline measures used in the home: _____

Describe child's peer relationships: _____

Student's interests and strengths: _____

Behaviors: Easily Distracted: Yes ☐ No ☐ Easily Frustrated: Yes ☐ No ☐ Aggressive: Yes ☐ No ☐
Independent: Yes ☐ No ☐ Impulsive: Yes ☐ No ☐ Temper Tantrums: Yes ☐ No ☐

If yes, explain: _____

_____

TRAUMATIC EVENTS/PSYCHOLOGICAL STRESSORS

Has the child been exposed to or affected by: Separation/Divorce: Yes ☐ No ☐ Serious family illness/death: Yes ☐ No ☐
Police or Department of Children and Families involvement: Yes ☐ No ☐ Catastrophic events: Yes ☐ No ☐
Homelessness: Yes ☐ No ☐
If yes, explain: _____

_____

Additional Information:

_____

_____

Clear Form

Miami-Dade County Public Schools
OBSERVATION OF PREKINDERGARTEN STUDENT BEHAVIORS

Child's Name_____ **Birthdate**_____ **Age**_____

Observer_____ **School**_____

To be completed by child's teacher(s) and/or therapist(s). **Please check the behaviors that occur more frequently than is typical for same-age peers. If no concerns, check the box marked age appropriate.**

I. Attending Behaviors

- ☐ Easily distracted
- ☐ Has short attention span
- ☐ Impulsive
- ☐ Needs help from adult to stay on task
- ☐ Needs excessive attention from teacher
- ☐ Acts upset by a change in plans
- ☐ Over-active/hyperactive
- ☐ Has difficulty remembering things
- ☐ Appears to daydream
- ☐ Age appropriate

II. Disruptive Behaviors

- ☐ Argumentative
- ☐ Physically aggressive (hits, kicks, destructive etc.)
- ☐ Self-injurious behavior e.g._____
- ☐ Verbally abusive
- ☐ Bullies peers
- ☐ Age appropriate

III. Indicators of Anxiety/Sadness

- ☐ Withdrawn
- ☐ Anxious/nervous
- ☐ Seems unhappy
- ☐ Becomes ill when upset or frustrated
- ☐ Easily overwhelmed
- ☐ Cries easily/inappropriately
- ☐ Exhibits inappropriate mood changes
- ☐ Age appropriate

IV. Language/Speech

- ☐ Has difficulty understanding instructions or directions
- ☐ Has difficulty naming people or objects
- ☐ Has difficulty speaking in sentences
- ☐ Has difficulty staying on topic
- ☐ Speech is difficult to understand
- ☐ Frequently stutters (e.g: m,m,m,many), repeats words, whole phrases or "gets stuck" while trying to say a word
- ☐ Voice is hoarse, raspy or nasal
- ☐ Age appropriate

V. Social/Emotional

- ☐ Has difficulty with self-control when frustrated
- ☐ Has difficulty sharing with other children
- ☐ Exhibits repetitive behavior e.g._____
- ☐ Becomes easily upset
- ☐ Displays unusual reactions to sensory stimulation (e.g. lights, sounds, smells, tastes, touch, etc.)
- ☐ Has difficulty joining in peer group play
- ☐ Avoids interaction with other children
- ☐ Has temper tantrums (length of tantrums _____)
- ☐ Has difficulty taking turns
- ☐ Lacks imaginative play
- ☐ Age appropriate

VI. Gross and Fine Motor Skills

- ☐ Has unsteady gait
- ☐ Appears clumsy or uncoordinated
- ☐ Has difficulty using a pencil or crayon
- ☐ Frequently drops, spills or knocks things over
- ☐ Age appropriate

VII. Adaptive/Self-Help Skills

- ☐ Has frequent toileting accidents
- ☐ Needs assistance washing and drying hands
- ☐ Needs assistance with eating e.g._____
- ☐ Age appropriate

Comments/Concerns:_____

_____

_____

Signature_____ **Date**_____

Miami-Dade County Public Schools
Hearing and Ear Health History

OTOLOGIC HISTORY: (Ear problems include but are not limited to ear infection, earaches, draining ears, medicine taken for an ear problem, the doctor noticed fluid behind the eardrum, hole in the eardrum, etc.)

1. How many ear problems has your child had?
   None ____ 1-2 _____ 3-5 _____ 6-10 _____ 10 or more _____

2. Has your child had an ear problem in the last 6 months? YES NO
   If yes, when? _____ What type of ear problem? _____
   Was medication given: YES NO

3. Does your child have any of the following?
   - Frequent runny nose: YES NO
   - Ringing or buzzing in the ear(s): YES NO
   - Frequent colds or sinus infections: YES NO
   - Dizziness: YES NO
   - Allergies: YES NO

4. Has anyone related to the child had any ear problems? YES NO
   Who? (parent, brother, sister, cousin, etc.) _____
   What type of ear problem?
   _____
   _____
   _____

5. Has your child ever been seen by an Ear, Nose & Throat (ENT) doctor? YES NO
   If yes, which doctor? _____ When? _____

6. Has your child ever had any ear surgery? YES NO
   If yes, describe:
   _____
   _____
   _____

7. Has your child previously had his/her hearing tested by an audiologist? YES NO
   If yes, by whom? _____ When? _____
   What were the results?
   _____
   _____

8. Does your child have any permanent hearing loss? YES NO
   If yes, describe:

   _____

   _____

   _____

   Has your child ever used amplification? YES NO
   If yes, is it current use or when were they last used?

   _____

   _____

****IF YOU HAVE A PREVIOUS AUDIOLOGICAL EVALUATION WITHIN ONE YEAR, PLEASE SUBMIT IT TO THE AUDIOLOGY DEPARTMENT FOR REVIEW PRIOR TO YOUR APPOINTMENT****