NEW MEXICO
Early Childhood
Education & Care Department

Family Support and Early Intervention Division
FAMILY INFANT TODDLER (FIT) PROGRAM

TRANSITION REFERRAL FORM

Date of Referral SentTo Part B:

CHILD INFORMATION		
First Name:	**MI:**	**Last Name:**
☐ **Male** ☐ **Female**	**DOB:**	
Chronological Age:	**Child's Diagnosis (if applicable):**	

PARENT INFORMATION		
Parent / Guardian Name(s):		
Street Address:		
City:	**State:**	**Zip code +4:**
Phone Number:	**E-mail:**	

FIT PROVIDER INFORMATION	
FIT Family Service Coordinator (FSC):	**FIT Agency:**
FSC Phone:	**FSC e-mail:**
Current IFSP Date:	
Provider agencies on the child's current IFSP: 1. 3. 2. 4.	

The FIT Family Service Coordinator will be contacting the school district to schedule a Transition Conference that will need to occur by _____ (90 days before child's 3rd birthday)

☐ *90-day timeline for this meeting cannot be met due to when the child started the FIT program.*

By signing this form, I agree that_____(FIT provider agency) can refer my child to the local school district.

_____ _____
Parent/Guardian Signature **Date**

_____ _____
Parent/Guardian Signature **Date**

_____ _____
FIT Family Service Coordinator Signature **Date**