

Children's Integrated Services: Family and Early Childhood Health, Mental Health & Early Intervention Services

Referral Date: ___/___/___ Re-referral: Yes No
 Individual Collecting This Intake Information: _____ Date: ___/___/___

Family Concerns (as indicated by the family):

Client Lives With:

County: _____ **Supervisory Union:** _____ **School:** _____

What type of services do you currently receive: | **Contact information of who helps you:**

Primary Health Care provider: Yes No

VDH-Children with Special Health Needs: Yes No

Child Development Clinic: Yes No

Child Care Provider: Yes No

Mental Health: Yes No

Substance Abuse Counseling: Yes No

Food / Nutrition: Yes No

WIC: Yes No

Assistance with Basic Needs (Housing, Employment, Economic Assistance): *Circle all that apply*

Other: _____

Previous Screenings and Evaluations (e.g. pregnancy, nutrition, sleep, or for children only – developmental delays, communication, movement, social / emotional, behavioral, or hearing / vision):

Type:	Location / Address / Phone:

Next Steps:

Primary Interventionist / Lead Service Coordinator:

Follow Up Information Provided to Referral Source: Yes No Date: ___/___/___