REFERRAL FORM-
CIS-01
Version 7-09

Children's Integrated Services:

Family and Early Childhood Health, Mental Health & Early Intervention Services

Is the Family Aware of This Referral? ☐ Yes ☐ No: ________________________________
(If "No" you are required to notify the parent/guardian before making a referral)
The Family Would Like to Speak With the Children's Integrated Services Intake Coordinator? ☐ Yes ☐ No

A. FAMILY CONTACT INFORMATION

Child's Name: Date of Birth: / / Age: Gender: ☐ M ☐ F

Parent(s)/Guardian(s)/Pregnant Woman's Name:

Primary Language: Is Interpreter Needed? ☐ Yes ☐ No	If Pregnant Woman, Her Date of Birth: / / Anticipated Due Date: / /
Mailing Address :	Physical Address:
Phone (Home/Work/Cell):	Email: Best Way to Contact the Family:

Custody: ☐ Family ☐ DCF: ______________ ☐ Other: ______________________________

B. INSURANCE/MEDICAID

☐ Medicaid / Dr. Dynasaur ☐ Private Insurance ☐ Both ☐ Uninsured ☐ Don't Know

C. REASON FOR REFERRAL

For Child:

- ❑ Health Concern
- ❑ Developmental Concern, Delay or Disability
  - ☐ Hearing / Vision ☐ Cognitive ☐ Behavioral ☐ Communication
  - ☐ Social / Emotional ☐ Motor / Physical ☐ Other: ______________
- ❑ CAPTA
- ❑ Risk / History of Abuse / Neglect / Family Violence
- ❑ Concerns with Nutrition, Diet, or Feeding
- ❑ Significant Birth Issues
- ❑ Sleep Concerns
- ❑ Diagnosed Condition: ____________________________

For Parent:

- ❑ History of Child Abuse or Neglect
- ❑ Domestic Violence
- ❑ Substance Abuse / Recovery Concerns
- ❑ Family Questions or Concerns about Child
- ❑ Homelessness / Unstable Housing
- ❑ Significant Medical Issues: __________________
- ❑ Legal Issues
- ❑ Parenting Concerns
- ❑ Teen Parent

D. FAMILY STRENGTHS AND RESILIENCE FACTORS:

E. REFERRAL SOURCE INFORMATION

Person Making Referral: ____ Referral Date:____/_____/_________
Agency/Organization: ____ Phone: _(_____)____-_______
Address: ____
Email: ____ Fax: ___________________
Provider/Physician Signature: ____ Role: __________________

THANK YOU
PLEASE SUBMIT THIS FORM TO YOUR REGIONAL CIS INTAKE COORDINATOR

Date Received: _______________________ Received By: ______________________________________