Service Coordination Agency
Early Intervention Referral Form (EI8045)

Department of Children & Youth
Department of Developmental Disabilities

REFERRAL TYPE

☐ New referral

☐ Transfer: EIDS # from (county) to (county)

CHILD AND CAREGIVER INFORMATION

Parent/Caregiver name:

Parent/Caregiver relationship to child:

Parent/Caregiver Contact Information (provide at least one) *Note: If transferring to another county, please list the new address if available.*

Address:

Phone number: Email address:

Child name:

Child date of birth:

Referral reason/notes:

REFERRER INFORMATION

Referrer agency name:

Referrer name:

Referrer role: ☐ SC ☐ PSP ☐ OCECD (Note: If diagnosis is listed, it is confirmed.)

Referrer contact information (provide at least one)

Phone number: Fax number:

Email address:

Address:

I have spoken to the above named parent/caregiver and confirm that the parent/caregiver has a concern about the child's development and would like to proceed with an Early Intervention program referral.

Printed name Date