## *North Carolina Infant-Toddler Program Referral Form*

|  |
| --- |
| **IDENTIFYING INFORMATION** |
| 1. Child’s Name:
 |       |  |       |  |       | Date of Birth: |       |
|  | Last |  | First |  | Middle |  |  |
|  Sex: [ ]  Male [ ]  Female | Age: |       | Race: |       | County of Residence: |       |
| 1. Parent’s Name:
 |       | Parent’s Name: |       |
| Mailing Address: |       | Mailing Address: |       |
| City, State, Zip |       | City, State, Zip |       |
| Home Phone Number: |       | Home Phone Number: |       |
| Work Phone Number: |       | Work Phone Number: |       |
| Cell Phone Number: |       | Cell Phone Number: |       |
| Email Address: |       | Email Address: |       |
| With whom does the child live? [ ]  Both Parents [ ]  Father [ ]  Mother [ ]  Foster Family [ ]  Other: |       |
|  Name, if different from parents: |       |
|  Mailing Address: |       |  |       |  |      |  |       |
|  | *Street* |  |  *City* |  | *State* |  | *Zip* |
|  County: |       | Home #: |       | Work #: |       | Cell #: |       |
|  If child is in legal custody of someone other than the person with whom he/she lives, complete the following: |  |
|  Legally Responsible Party:  |       |
|  Mailing Address: |       |  |       |  |      |  |       |
|  | *Street* |  | *City* |  | *State* |  | *Zip* |
|  County: |       | Home #: |       | Work #: |       | Cell #: |       |
|  Is a Surrogate Parent needed? | [ ]  Yes [ ]  No |
| 1. Primary Person, Phone Number, and Time to Contact:
 |       |
| **REFERRAL SOURCE AND CONCERNS:** |
| 1. Name of Person Making Referral:
 |       |
|  | Agency/Office for which Referring Person Works:  |       |
|  |       |  |       |  |       |
|  | *Address:* |  | *Phone:* |  | *Fax:* |
| 1. Specific Concerns of Referring Person:
 |       |
|  |       |
|  |       |
| 1. If the referral is not from parents, has the referral been discussed with the child’s family? [ ]  Yes [ ]  No
 |
| **ADDITIONAL INFORMATION:** |
| 1. Primary Language of Parent:
 |       | Of Child: |       |
|  Interpreter Needed? [ ]  Yes [ ]  No If yes, for whom? |       | Translation needed? [ ]  Yes [ ]  No |
| 1. Does child have a Case Manager? [ ]  Yes [ ]  No [ ]  Don’t know
 |
|  | If yes, indicate name and with what agency: |       |
|  | Directions to Home: |       |
|  |       |
| Person Completing Form:  |       |  |       |
|  |  *(if other than CDSA staff)* |  | *Date* |
|  |  |  |  |
| **For CDSA Use:** |  |  |
| Referral Date: |       | Name of CDSA Representative Accepting Referral: |       |
| IFSP Due Date: |       | Name of EISC & Date Assigned: |       |
| Transition Reminders: 135-day date:  |       | 90-day date:  |       |  |
| Confirmed Race/Ethnicity:  |       |
| 1. *Ethnic Origin (choose one):* [ ]  Non-Hispanic/Latino [ ]  Hispanic
 |
| 1. *If Ethnic Origin is Hispanic, please choose one:*

[ ]  Hispanic Cuban [ ]  Hispanic Mexican American [ ]  Hispanic/Other [ ]  Hispanic Puerto Rican  |
| 1. *Race (choose as many as apply)*: [ ]  American Indian/Alaskan Native [ ]  Black or African American [ ]  Native Hawaiian/Other Pacific Islander [ ]  Asian [ ]  White
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