

# Children's Integrated Services:

## Nursing & Family Support, Early Intervention, & Early Childhood & Family Mental Health 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/Postpartum Woman's Name: \_\_\_\_\_

Primary Language: \_\_\_\_\_ Pregnant/Postpartum Woman's Date of Birth: \_\_\_-\_\_\_-\_\_\_  
 Is Interpreter Needed?  Yes  No Anticipated Due Date or Date of Delivery: \_\_\_-\_\_\_-\_\_\_

Mailing Address: \_\_\_\_\_ Physical Address: \_\_\_\_\_

Phone (Home/Work/Cell): \_\_\_\_\_ Email: \_\_\_\_\_  
 Best Way to Contact the Family: \_\_\_\_\_

Custody:  Family  DCF: \_\_\_\_\_  Other: \_\_\_\_\_

**B. REASON FOR REFERRAL**

For Child:	For Parent:
<input type="checkbox"/> Health Concern <input type="checkbox"/> Developmental Concern, Delay or Disability <input type="checkbox"/> Hearing / Vision <input type="checkbox"/> Cognitive <input type="checkbox"/> Behavioral <input type="checkbox"/> Communication <input type="checkbox"/> Social / Emotional <input type="checkbox"/> Motor / Physical <input type="checkbox"/> Other: _____ <input type="checkbox"/> CAPTA <input type="checkbox"/> Risk / History of Abuse / Neglect / Family Violence <input type="checkbox"/> Concerns with Nutrition, Diet, or Feeding <input type="checkbox"/> Significant Birth Issues <input type="checkbox"/> Sleep Concerns <input type="checkbox"/> Diagnosed Condition: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> History of Child Abuse or Neglect <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Substance Abuse / Recovery Concerns <input type="checkbox"/> Family Questions or Concerns about Child <input type="checkbox"/> Homelessness / Unstable Housing <input type="checkbox"/> Legal Issues <input type="checkbox"/> Parenting Concerns <input type="checkbox"/> Teen Parent <input type="checkbox"/> Prenatal / Postpartum <input type="checkbox"/> Significant Medical Issues: _____ <input type="checkbox"/> Other: _____

**C. ADDITIONAL COMMENTS, FAMILY STRENGTHS, AND RESILIENCE FACTORS**

\_\_\_\_\_

**D. REFERRAL SOURCE INFORMATION**

Person Making Referral: \_\_\_\_\_ Referral Date: \_\_\_-\_\_\_-\_\_\_  
 Agency/Organization: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
 Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Email: \_\_\_\_\_ Role: \_\_\_\_\_

**E. MEDICAL PROVIDER ASSESSMENT INFORMATION – If Referral from a Medical Provider**

Provider/Physician Signature: \_\_\_\_\_ Referral Date: \_\_\_-\_\_\_-\_\_\_  
 Print Provider/Physician Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
 Email: \_\_\_\_\_  Initial Assessment  28 Week  6 Month  
 Medicaid/Dr. Dynasaur  Private Insurance  Uninsured  Insurance Status Unknown

**THANK YOU • PLEASE SUBMIT THIS FORM TO YOUR REGIONAL CIS INTAKE COORDINATOR**  
 Date Received: \_\_\_\_\_ Received By: \_\_\_\_\_