



146 State House Station  
 Augusta, Maine 04333  
 Phone: 877-770-8883  
 Fax: (207) 624-6661

### Child Find Intake Referral Form

Please complete the following and fax, with supporting documentation to Child Development Services at (207) 624-6661 or call 877-770-8883.

#### Child Information (all information is required)

**Today's Date:**

<b>Name</b> (last, first)	<b>Date of Birth</b>	<b>Age Today</b> (years, months)	<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Physical Address</b> (street, city, state, zip)	<b>Child lives with:</b>	<b>Language spoken at home:</b>	<b>Interpreter needed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Does this child attend childcare or preschool?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Name of childcare or preschool</b>		<b>Scheduled days</b>
<b>Are any other agencies working with this child or family?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If so, please list</b>			

#### Parent or Guardian Contact Information (contact info for at least one parent or guardian is required)

<b>Name</b>	<b>Name</b>
<b>Mailing Address</b> <input type="checkbox"/> same as child	<b>Mailing Address</b> <input type="checkbox"/> same as child
<b>Phone</b> <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	<b>Phone</b> <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
<b>Email</b>	<b>Email</b>
<b>Relationship to the Child</b> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Foster <input type="checkbox"/> Relative:	<b>Relationship to the Child</b> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Foster <input type="checkbox"/> Relative:
<b>Are the parent(s) or guardian(s) named above aware of this referral?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If no, why?</b>	

#### Primary Healthcare Provider

<b>Name</b>	<b>Phone</b>
<b>Practice Name</b>	<b>Fax</b>

#### Referral Source Information

<b>Name</b>	<b>Phone</b>	<b>Fax</b>
<b>Agency</b>	<b>Email</b>	
<b>Relationship to the Child</b> <input type="checkbox"/> Parent or Guardian <input type="checkbox"/> Childcare Provider <input type="checkbox"/> Primary Healthcare Provider <input type="checkbox"/> DHHS <input type="checkbox"/> Other Relative <input type="checkbox"/> Head Start <input type="checkbox"/> Hospital <input type="checkbox"/> Other (please specify) <input type="checkbox"/> Friend <input type="checkbox"/> Public School Program <input type="checkbox"/> Therapist		

#### Reason for this Referral

<b>Area(s) of Concern</b> <input type="checkbox"/> All Developmental Areas (includes 6 following areas) <input type="checkbox"/> Speech and Language <input type="checkbox"/> Cognitive <input type="checkbox"/> Gross Motor <input type="checkbox"/> Fine Motor <input type="checkbox"/> Social / Emotional <input type="checkbox"/> Adaptive / Self Care <input type="checkbox"/> Autism <input type="checkbox"/> Behavior <input type="checkbox"/> CAPTA (Child Abuse Prevention and Treatment) <input type="checkbox"/> Drug Affected Baby <input type="checkbox"/> Hearing <input type="checkbox"/> Prematurity <input type="checkbox"/> Vision <input type="checkbox"/> Other:	<b>Diagnosis</b>
	<b>Explanation of Concern(s)</b>

#### For CDS Use

<b>Received by:</b>	<input type="checkbox"/> Part C Referral <input type="checkbox"/> Transition Age <input type="checkbox"/> Part B Referral	<b>ID #</b>
<b>Regional Site Notified:</b>		<b>Referral Date:</b>