

# Alabama's Early Intervention System

## Child Find Referral Form

To make a referral by phone: 1-800-543-3098

Mail to: ADRS/EI, 602 S. Lawrence St., Montgomery, AL 36104 or Fax to: Child Find Fax # (334) 293-7393 or email to: [margaret.pouncey@rehab.alabama.gov](mailto:margaret.pouncey@rehab.alabama.gov) and [patricia.bozeman@rehab.alabama.gov](mailto:patricia.bozeman@rehab.alabama.gov) and [tonya.gandy@rehab.alabama.gov](mailto:tonya.gandy@rehab.alabama.gov) for more information visit: <http://rehab.alabama.gov/individuals-and-families/early-intervention>

\*Please print clearly and complete all blanks - no stamps or labels\*

### INFANT/TODDLER INFORMATION

1. SSN# (if available): \_\_\_\_\_ 2. Date of Birth: \_\_\_\_\_ 3. Sex: F  M
4. Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI/Name: \_\_\_\_\_
5. Is your child of Hispanic or Latino origin? Y  N  6. Child's Primary Race: \_\_\_\_\_
- \* If Primary Race is Two or More Races:  Hispanic/Latino  American Indian/Alaska Native  Asian
- (Mark appropriate boxes)  Black/African American  Hawaiian/Pacific Islander  White
7. Home Language: \_\_\_\_\_ 8. Medicaid: Y  N  Medicaid # \_\_\_\_\_
9. Private Insurance: Y  N  10. CHIP/All Kids Y  N

### CHILD RELATION INFORMATION

11. First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_
12. Relation Type: \_\_\_\_\_ 13. Is this Primary relation? Y  N  14. Is address same as child's? Y  N
15. Mailing Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ 16. County: \_\_\_\_\_
17. Physical Address (if different from above): \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ 18. County: \_\_\_\_\_
19. Primary contact #: ( ) \_\_\_\_\_ 20. Alternate contact #: ( ) \_\_\_\_\_  
Alternate contact #: ( ) \_\_\_\_\_ Work Phone #: ( ) \_\_\_\_\_ Ext #: \_\_\_\_\_
- Primary Contact Email address: \_\_\_\_\_

### REFERRAL SOURCE INFORMATION

21. Person making referral: \_\_\_\_\_ 22. Referral Source: \_\_\_\_\_
23. County: \_\_\_\_\_ 24. Phone: \_\_\_\_\_ 25. Fax: \_\_\_\_\_
26. Reason for referral: \_\_\_\_\_
27. How family became aware of Child Find: \_\_\_\_\_ Additional Information: \_\_\_\_\_
- Refer to Service Coordinator/Caseload ID # (leave blank if unknown): \_\_\_\_\_
- Date Mailed/Faxed to Child Find: \_\_\_\_\_ Sender's Name/Phone #: \_\_\_\_\_

### PHYSICIAN/CRNP USE ONLY

28. I certify that the child named above has a confirmed diagnosis of \_\_\_\_\_
29. Printed Name of Physician/CRNP: \_\_\_\_\_ 30. Phone #: \_\_\_\_\_
31. Signature of Physician/CRNP: \_\_\_\_\_ Today's date: \_\_\_\_\_

### STATE OFFICE USE ONLY

- New Case ID#: \_\_\_\_\_ SS# or T#: \_\_\_\_\_
- Referral taken by: \_\_\_\_\_ Date taken: \_\_\_\_\_ Received by:  phone  email  fax Processed by: \_\_\_\_\_ Official referral/entry date: \_\_\_\_\_
- ATTACHMENT: \_\_\_\_\_  Signed release of information