VERMONT
DEPARTMENT FOR CHILDREN AND FAMILIES
CHILD DEVELOPMENT DIVISION

REFERRAL
FORM-CIS-01
Version 6-12

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:
Is Interpreter Needed? ☐ Yes ☐ No

Pregnant/Postpartum Woman's Date of Birth: - -
Anticipated Due Date or Date of Delivery: - -

Mailing Address:

Physical Address:

Phone (Home/Work/Cell): ( ) - ext:

Email:
Best Way to Contact the Family:

Custody: ☐ Family ☐ DCF: ☐ Other:

B. REASON FOR REFERRAL

For Child:

- ☐ Health Concern
- ☐ Developmental Concern, Delay or Disability
  - ☐ Hearing / Vision ☐ Cognitive ☐ Behavioral ☐ Communication
  - ☐ Social / Emotional ☐ Motor / Physical ☐ Other:
- ☐ CAPTA
- ☐ Risk / History of Abuse / Neglect / Family Violence
- ☐ Concerns with Nutrition, Diet, or Feeding
- ☐ Significant Birth Issues
- ☐ Sleep Concerns
- ☐ Diagnosed Condition:
- ☐ Child Care
- ☐ Other:

For Parent:

- ☐ Family Questions or Concerns about Child
- ☐ Child Care
- ☐ Parenting Concerns
- ☐ Teen Parent
- ☐ Prenatal / Postpartum
- ☐ Nurse Family Partnership program
- ☐ Homelessness / Unstable Housing
- ☐ Legal Issues
- ☐ Significant Medical Issues:
- ☐ History of Child Abuse or Neglect
- ☐ Domestic Violence
- ☐ Substance Abuse / Recovery Concerns
- ☐ Other:

C. ADDITIONAL COMMENTS, FAMILY STRENGTHS, AND RESILIENCE FACTORS

D. REFERRAL SOURCE INFORMATION

Person Making Referral:
Agency/Organization:
Address:
Email:

Referral Date: - -
Phone: ( ) - ext:
Fax: ( ) - ext:
Role:

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

Provider/Physician Signature:
Print Provider/Physician Name:
Email:

Referral Date: - -
Phone: ( ) - ext:
☐ 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: - -