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 both: margaret.pouncey@rehab.alabama.gov and tonya.gandy@rehab.alabama.gov

for more information visit: www.rehab.alabama.gov/ei

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'? 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 USE ONLY

28. I certify that the child named above has a confirmed diagnosis of _____

29. Printed Name of Physician: _____ 30. Phone #: _____

31. Signature of Physician: _____ 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

Revised 10/2015