Tioga County Early Intervention & Child Find Referral Form

Office Use Only	**45 Day date:**	**Referral #**

Referral date:

Child's Name:

Birth Date: Sex: ☐ F ☐ M Dominant Language:

Mother's Name:

Father's Name:

Foster/Guardian Name: (if different) Is Parent/Guardian aware of referral? ☐ Yes ☐ No

Address:

Phone: School District:

Email:

Person Making Referral:

Agency/Facility: Telephone:

Primary Care Physician:

Confirmed Diagnosis: Insurance Type:

Suspected Area of Concern (please explain): OR

☐ CPS referral only

Other notes:

For Office Use Only: EIO Designated SC: _____ Date: _____

Date contacted parent/ guardian:_____

☐ **EI Referral** ☐ **Child Find Referral** **Notes:**

PLEASE FAX COMPLETED FORM TO 607-223-7131