

Please Type
or Print
Clearly



The Resource Exchange Early Intervention Program Referral Form

Office Use Only:
 CCMSWeb
 HERO

Today's Date (Referral Date): _____

Parental Agreement: Yes NO - STOP

Referral Source: _____

Who told caller about us? _____

TRE USE ONLY: SERVICE COORDINATOR ASSIGNED: _____

CHILD'S INFORMATION:

First Name	Middle Name	Last Name	
DOB	Gender <input type="checkbox"/> Boy <input type="checkbox"/> Girl	Birth Order (1 st twin, etc.)	Primary Language
Social Security Number	Medicaid ID	School District	
Race – check <input type="checkbox"/> Caucasian <input type="checkbox"/> African-Amer <input type="checkbox"/> Asian/Pac Isl <input type="checkbox"/> Amer Indian/Alaskan <input type="checkbox"/> Unknown	Hispanic? Check if Yes <input type="checkbox"/>	County of Residence <input type="checkbox"/> El Paso <input type="checkbox"/> Park <input type="checkbox"/> Teller	
Concerns about the child: _____ _____			

FAMILY'S INFORMATION:

Parent/Guardian First Name(s)	Parent/Guardian Last Name(s)	
Address		
City	State	ZIP Code
Home Phone	Cell Phone	Work Phone
Email Address →		

Relationship to Child – check appropriate box(es)

<input type="checkbox"/> Legal Parent/Guardian	<input type="checkbox"/> Kinship Care	If in Foster Care, Caseworker Name and Phone
<input type="checkbox"/> Foster Parent – bio parental rights	<input type="checkbox"/> intact <input type="checkbox"/> terminated	

INSURANCE INFORMATION:

<input type="checkbox"/> Private – Name of Insurance Company	
<input type="checkbox"/> Child Health Plan Plus (CHP+) – ID#	<input type="checkbox"/> Medicaid – write in ID number above

Physician's Name	Discipline/Name of Practice	Phone Number
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TRE USE ONLY: 45-Day Timeline for Initial IFSP Development: _____

Referral Completed by: _____

FAX TO TRE: 785-3769. Questions? Call Linda: 785-3732. Thank you!

Eff. 8/29/2008