Washington County
Referral Form for Child Find / Early Intervention Program

Please supply the following information. This information is needed to process the referral. Please fill this form out completely with the necessary attachments and FAX to:
Dianne Cantiello, Early Intervention Official at 518-746-2461.

Referred By: _____ Date of Referral:_____

Address: _____ Phone: _____

Child's Name: _____ **DOB: _____ Sex: □ M □ F**
Race/Ethnicity: _____
Address: _____ **Phone: _____**

Reason For Referral:
□ At Risk of Developmental Delay □ Suspected Developmental Delay
□ Confirmed Diagnosis (ICD10 code: _____)

_____/_____/_____ (m/d/year) Date of last Dr.'s visit

Area of concern/suspected delay:
□ Cognitive □ Communication □ Adaptive
□ Physical (including vision & hearing) □ Social/Emotional

Parent Names:
Mother: _____ DOB: _____
Father: _____ DOB: _____

Health Insurance Information:

Does the Child have Health Insurance?	□ Y	□ N	
Medicaid?	□ Y	□ N	CIN #: _____
Child Health Plus?	□ Y	□ N	ID #: _____
Commercial Insurance?	□ Y	□ N	ID #: _____

Parents are aware <u>and</u> consent to this referral: □ Y □ N

Please attach copy of the following:
□ Copies of any insurance card.
□ Most Recent Physical
□ Immunization Record
□ Vision & Hearing screening
□ Physician's script for a developmental evaluation with ICD-10 code(s) for concern(s)