



Early Intervention

CHILD & FAMILY CONNECTIONS

Serving Champaign, Ford, Iroquois, Livingston, McLean and Vermilion Counties

Phone: 800-877-1152 Fax: (217) 442-8153

EI Number: _____

Child/Family Con. Number: _____

LSA Number: _____

I. CHILD'S INFORMATION

Name: _____ (Last) (First) (Middle)			*Social Security #: _____			
*AKA: _____ (Also Known As)			*Receiving SSI?	Yes	No	Pending
*Address: _____ _____ _____			*Medicaid Eligible?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*County: _____			*IDPA Recipient #	_____		
*Date of Birth: _____ / _____ / _____			US Citizen	Yes	No	
*Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female			Child	<input type="checkbox"/>	<input type="checkbox"/>	
*Race: _____			Parent	<input type="checkbox"/>	<input type="checkbox"/>	
*Language: _____			Illinois Resident			
*Living Arrangement: _____			Child	<input type="checkbox"/>	<input type="checkbox"/>	
			Parent	<input type="checkbox"/>	<input type="checkbox"/>	
			Primary Care Physician:	_____		

II. REFERRAL SOURCE

Name/Agency: _____	*Referral Sources		
Address: _____ _____	<input type="checkbox"/> Ed. Agency	<input type="checkbox"/> LIC	<input type="checkbox"/> Physician
Telephone Number: _____	<input type="checkbox"/> Hosp. Diag. Prog.	<input type="checkbox"/> Parent/Relative	
Fax Number: _____	<input type="checkbox"/> Health Nurse	<input type="checkbox"/> Social Service	
Reason for Referral: _____ _____ _____	<input type="checkbox"/> Other		
	Code/Description		
	Type of Referral:		
	<input type="checkbox"/> Written	<input type="checkbox"/> Verbal/Telephone	
	Family has been informed of referral:		
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

III. PRIMARY CONTACT FOR SCHEDULING APPOINTMENTS

* Name: _____ (Last) (First) (Middle)	* Relationship to Child _____				
* Address: _____ _____ _____	* Language: _____				
* Home Phone: _____			Yes	No	
* Time to Call: _____			* Legally Responsible	<input type="checkbox"/>	<input type="checkbox"/>
* Work/Alternative Phone: _____			* Financially Responsible	<input type="checkbox"/>	<input type="checkbox"/>
			* Social Security #:	_____	
			(If financially responsible)	_____	

Referral Completed By: _____ Date of Referral: _____

* Initial Service Coordinator: _____

Supervisor: _____ Date: _____ IFSP Due: _____

