

**CFC #21 Early Intervention Referral Form**

EI# \_\_\_\_\_

Reopen? \_\_\_Yes \_\_\_No

Participant ID # \_\_\_\_\_

**Child's Information**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

County: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender: Male \_\_\_ Female \_\_\_

Language: \_\_\_\_\_

Race: \_\_\_\_\_

# of family members in home: \_\_\_\_\_

DCFS Ward? \_\_\_Yes \_\_\_No

Caseworker Name/Phone: \_\_\_\_\_  
\_\_\_\_\_

Medicaid Elig? Yes \_\_\_ No \_\_\_ Pending \_\_\_

IDPA Recipient#: \_\_\_\_\_

IDPA ID#: \_\_\_\_\_

Insurance? Yes \_\_\_ No \_\_\_

Insurance Name: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Illinois Resident?

Child: Yes \_\_\_ No \_\_\_

Parent: Yes \_\_\_ No \_\_\_

**Referral Source**

Name/Agency: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone #: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How did you find out about EI/CFC?  
\_\_\_\_\_  
\_\_\_\_\_

Referral Source Agency type:

\_\_\_Ed. Agency \_\_\_Physician \_\_\_WIC

\_\_\_Hospital \_\_\_Parent/Relative

\_\_\_Health Dept. \_\_\_Social Service

Other: \_\_\_\_\_

Type of Referral: \_\_\_phone \_\_\_written

Family been informed? \_\_\_yes \_\_\_no

Pediatrician: \_\_\_\_\_

**Primary Contact for Scheduling Appointments**

Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Legally Responsible: \_\_\_yes \_\_\_no

Financially Responsible: \_\_\_yes \_\_\_no

Other comments/contacts: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referral completed by: \_\_\_\_\_

Referral Date: \_\_\_\_\_

Service Coordinator: \_\_\_\_\_

IFSP Due Date: \_\_\_\_\_