

Referral/Intake Information
Suffolk County Early Intervention Program

Date Of Referral: _____ Time: _____ 45 Days _____

Date Assigned (If Different): _____ Service Coordinator _____

Did Parent Consent To This Referral? Yes [] No [] Reopen []

Who Referred Parent? _____ ICHAP _____

Name Of Referral Source: _____

Agency: _____

If Foster Care: Caseworker: _____ Team: _____

Phone: _____

Address: _____

Child's Information:

Child's Name: _____, _____ M [] F [] DOB: _____
(Last) (First)

Parent: Mother _____, _____

Father _____, _____

Guardian/Foster Parent: _____

Child's Address: _____

Home Phone (631) _____ - _____ Alternate Phone: () _____ - _____

School District: _____

Language At Home: _____

Area(s) Of Concern: Adaptive [] Cognitive []

Communication [] Social/Emotional [] Physical []

Confirmed Diagnosis/Comments: