VERMONT
DEPARTMENT FOR CHILDREN AND FAMILIES
CHILD DEVELOPMENT DIVISION

REFERRAL
FORM-CIS-01
Version 12-18

Children's Integrated Services: Nursing, Family Support, Early Intervention, Early Childhood & Family Mental Health, and Specialized Child Care Services

The Woman/Parent/Guardian/Child Care Provider or Director has given verbal permission for this referral:
☐ Yes ☐ No: (If "No," you are required to obtain their verbal permission before making a referral)
This person would like to speak with the Children's Integrated Services Coordinator? ☐ Yes ☐ No

A. CONTACT INFORMATION for INDIVIDUAL(S) BEING REFERRED

Child's Name: Date of Birth: Age: Gender: ☐ M ☐ F

Parent(s) / Guardian(s) / Pregnant / Postpartum Woman's Name:

Child Care Provider/Director's Name and Program Name (if different):

Primary Language:
Is Interpreter Needed? ☐ Yes ☐ No

Pregnant/Postpartum Woman's Date of Birth: - -
Anticipated Due Date or Date of Delivery: - -

Mailing Address:

Physical Address:

Phone (Home/Work/Cell): ( ) - ext:

Email:
Best Way to Contact them:

Custody: ☐ Parent(s) ☐ Foster Care (DCF FSD): ☐ Legal Guardian ☐ Kin (no legal status)

B. REASON FOR REFERRAL

For Child:

☐ Health
☐ Developmental Concern, Delay or Disability
- ☐ Hearing / Vision ☐ Cognitive ☐ Behavioral ☐ Adaptive
- ☐ Communication ☐ Social / Emotional ☐ Motor / Physical
- ☐ Other:

☐ Family Services substantiated abuse/neglect (CAPTA)
☐ Risk / History of Abuse / Neglect / Family Violence
☐ Concerns with Nutrition, Diet, or Feeding
☐ Significant Birth Issues
☐ Sleep Concerns
☐ Child Care
☐ Diagnosed Condition:
☐ Other:

For Woman/Parent/Guardian/Child Care Program:

☐ Child Care Questions from Parent
☐ Child Care Questions from Child Care Provider
☐ Health of parent
☐ Lactation/Breastfeeding
☐ Oral Health for parent/child
☐ Questions or Concerns about Child(ren)
☐ Homelessness / Unstable Housing
☐ Domestic Violence
☐ Parenting Questions/Concerns
☐ Prenatal Questions/Concerns
☐ Postpartum Questions/Concerns
☐ Other:

C. ADDITIONAL COMMENTS, STRENGTHS, AND RESILIENCE FACTORS

D. REFERRAL SOURCE INFORMATION

Person Making Referral:
Agency/Organization:
Address:
Email:

Referral Date: - -
Phone: ( ) - ext:
Fax: ( ) - ext:
Role:

E. MEDICAL PROVIDER ASSESSMENT INFORMATION – If Referral from a Medical Provider

Provider/Physician Signature:
Print Provider/Physician Name:
Email:

Referral Date: - -
Phone: ( ) - ext:
☐ Initial Assessment ☐ 28 Week ☐ 6 Month

Insurance: ☐ Medicaid/Dr. Dynasaur ☐ Private Insurance ☐ Uninsured ☐ Insurance Status Unknown
UID: _____

THANK YOU • PLEASE SUBMIT THIS FORM TO YOUR REGIONAL CIS COORDINATOR

Date Received: - - Received By: