

REFERRAL TO WESTCHESTER COUNTY DEPARTMENT OF HEALTH

DATE: _____

TO: EARLY INTERVENTION PROGRAM (0-3 YEARS)
CHILDREN WITH SPECIAL NEEDS
WESTCHESTER COUNTY DEPARTMENT OF HEALTH
145 HUGUENOT STREET-8TH FLOOR
NEW ROCHELLE, NEW YORK 10801
TELEPHONE: (914)813-5094

FAX: (914)813-5093

FROM: _____ ORGANIZATION: _____

ADDRESS: _____

TELEPHONE: _____ FAX: _____

WE ARE REFERRING THE FOLLOWING CHILD TO YOUR EARLY INTERVENTION PROGRAM:

CHILD'S NAME: _____ DATE OF BIRTH: _____

PARENT/GUARDIAN: _____ RELATIONSHIP: _____

ADDRESS: _____

TELEPHONE: _____ WORK: _____

REASON FOR REFERRAL (PLEASE SPECIFY) _____

DOES THIS FAMILY NEED INFORMATION IN SPANISH? [] YES [] NO

ALTERNATE CONTACT: (IF APPLICABLE) [] FOSTER CASE [] OTHER

COMMENT: _____

NAME: _____ TELEPHONE: _____

ADDRESS: _____

THIS CHILD IS : [] SUSPECTED OF HAVING A DISABILITY OR DELAY
[] SUSPECTED OF BEING AT RISK OF DEVELOPING A DISABILITY OR DELAY

ACKNOWLEDGEMENT

TO: _____ DATE: _____

ADDRESS: _____

FROM: WESTCHESTER COUNTY DEPARTMENT OF HEALTH/ EARLY INTERVENTION PROGRAM

This is to acknowledge that we have received your referral of the following child for the Early Intervention Program:

CHILD'S NAME: _____ DATE OF BIRTH: _____

INITIAL SERVICE COORDINATOR: _____ TELEPHONE: _____

EARLY INTERVENTION OFFICIAL DESIGNEE: _____ TELEPHONE: _____