

Who referred you? _____

Why? _____

CHILD'S FAMILY Please list all the people who currently live in your child's home, *including* the child

First	Name MI	Last	Birth date (mm/dd/yy)	Sex M / F	Relationship to child

List parents and / or siblings who *do not* currently live with your child

First	Name MI	Last	Birth date (mm/dd/yy)	Sex M / F	Relationship to child

YOUR CHILD'S CURRENT MEDICAL PROVIDER(S): (Use another sheet to provide additional information)

Provider	Name	City / State
Primary care medical provider		
Other medical specialists including complementary/alternative providers		

May we have your **permission** to notify the primary care medical provider you listed above with the date of your child's CDC appointment? Yes No

Signature _____

Date ____/____/____

HOSPITALIZATIONS and/or SURGERY:

Please provide information about all surgeries and overnight hospitalizations, ***including birth:*** (Use another sheet to provide additional information)

Date	Hospital (City / State)	Length of Stay	Reason for admission
	Birth Hospital:		Birth

MEDICAL TESTS, PROCEDURES and ADDITIONAL EVALUATIONS:

Please provide information about all tests, procedures and evaluations your child has had such as CT, MRI scans, EEGs, or evaluations by a neurologist, geneticist, orthopedist, cardiologist, psychiatrist, nutritionist etc. (Use another sheet to provide additional information)

Date	Location / Provider	Reason for Eval?	Result(s) of Eval?

EDUCATIONAL / COMMUNITY RESOURCES:

	Provider	Contact information	Date(s) of Service <small>(indicate year if you don't remember exact dates)</small>
<input type="checkbox"/>	☞ Children's Integrated Services (CIS) – Early Intervention (formerly FITP)		
<input type="checkbox"/>	☞ CIS – Early Childhood & Family Mental Health Services (formerly CUPS)		
<input type="checkbox"/>	☞ CIS – Nursing & Family Support Services (formerly Healthy Babies, Kids, & Families)		
<input type="checkbox"/>	Early Education or Early Childhood Program such as EEE		
<input type="checkbox"/>	Head Start / Early Head Start		
<input type="checkbox"/>	Daycare provider(s)		
<input type="checkbox"/>	Private or other Preschool		
<input type="checkbox"/>	Developmental Services/Bridge		
<input type="checkbox"/>	Mental Health provider		
<input type="checkbox"/>	Home Health Care; Visiting Nurses (VNA)		

Other Services:

- Personal Care Services, *frequency:* _____
- WIC _____
- SSI _____
- Katie Becket Waiver _____
- Other _____
- Other _____

For Children Enrolled in School:

Current school / Home school _____

Address: _____

Current grade: _____ IEP ? Yes No 504 Plan ? Yes No

Services your child is currently receiving (Check all that apply. List the provider and frequency of therapy.)

- Special education _____
- Occupational therapy _____
- Physical therapy _____
- Speech therapy _____
- Case/care management _____
- Nutritionist _____
- Classroom aide _____
- Behavioral support _____
- Vision support _____
- Hearing support _____
- Psychotherapy / counseling _____
- Autism specialist _____
- Communication enhancement (e.g., sign language, communication board, or computer) _____

**★★ Please fill out an Authorization to Disclose Information form for
ANY medical, educational, or community service provider you listed in this form.
If need more authorization forms either photocopy a blank or contact the CDC office for more. ★★**

NOTE: Please indicate the amount of time it took you to complete this paperwork at the top of page 1.
Thank you!