VERMONT
DEPARTMENT FOR CHILDREN AND FAMILIES
CHILD DEVELOPMENT DIVISION

WINSTON PROUTY
Center for Child and Family Development

REFERRAL
FORM-CIS-01
*Version 5-13*

# Children's Integrated Services:

**Nursing, Family Support, Early Intervention, Early Childhood & Family Mental Health, and Specialized Child Care Services**

**Brattleboro CIS Coordinator, Alison Wheeler, 802-257-2101 x 213, Fax # 802-258-2413**

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)
He/She 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: English
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):
802-

Email:
Best Way to Contact them: phone

Custody: ☒ Family ☐ DCF: ☐ Other:

## B. REASON FOR REFERRAL

**For Child:**

- ☐ Health Concern
- ☐ Developmental Concern, Delay or Disability
  - ☐ Hearing / Vision ☐ Cognitive ☐ Behavioral ☐ Communication
  - ☐ Social / Emotional ☐ Motor / Physical ☐ Other:
- ☐ CAPTA
- ☐ Risk / History of Abuse / Neglect / Family Violence
- ☐ Concerns with Nutrition, Diet, or Feeding
- ☐ Significant Birth Issues
- ☐ Sleep Concerns
- ☐ Diagnosed Condition:
- ☐ Child Care
- ☐ Other:

**For Woman/Parent/Guardian/Child Care Program:**

- ☐ Child Care
- ☐ Parenting Concerns
- ☐ Teen Parent
- ☐ Prenatal / Postpartum
- ☐ Legal Issues
- ☐ Questions or Concerns about Child(ren)
- ☐ Nurse Family Partnership Program
- ☐ Homelessness / Unstable Housing
- ☐ Significant Medical Issues:
- ☐ History of Child Abuse or Neglect
- ☐ Domestic Violence
- ☐ Substance Abuse / Recovery Concerns
- ☐ Other:

## C. ADDITIONAL COMMENTS, STRENGTHS, AND RESILIENCE FACTORS

## D. REFERRAL SOURCE INFORMATION

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

Referral Date:
Phone: ( )
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

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

Date Received: Received By: