VERMONT
DEPARTMENT FOR CHILDREN AND FAMILIES
CHILD DEVELOPMENT DIVISION

REFERRAL
FORM-CIS-01
Version 03-21

Children's Integrated Services:

Strong Families Vermont, Early Intervention, Early Childhood & Family Mental Health, & Specialized Child Care

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, except CAPTA)

A. CONTACT INFORMATION for INDIVIDUAL(S) BEING REFERRED

Client's Name: Client's Date of Birth: Pronouns: Gender: ☐ M ☐ F

Client Identified Ethnicity: ☐ Hispanic/Latinx or of Spanish origin of any race ☐ Non-Hispanic/Latinx/of Spanish origin

Client Identified Race: ☐ American Indian/AK. Native ☐ Asian ☐ Black/African Amer. ☐ White ☐ 2 or More Races ☐ Other as Identified by Client/Family:

Note: *This information is only used by the State to meet federal grant reporting requirements, not to determine services.*

Client is a: ☐ Child (Parent/Guardian's Name:) ☐ Pregnant Person ☐ Child Care Program

Primary Language: Is Interpreter Needed? ☐ Yes ☐ No	Pregnant Person's Anticipated Due Date: - - Best Way to Contact Client:
Mailing Address:	Physical Address:
Phone (Home/Work/Cell): ( ) - ext:	Email:

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

B. REASON FOR REFERRAL

For Child:	For Woman/Parent/Guardian/Child Care Program:
☐ 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 ☐ Nutrition, Diet, or Feeding ☐ Significant Birth Issues ☐ Sleep Concerns ☐ Child Care Access ☐ Diagnosed Condition: ☐ Other:	☐ Child Care Search/Access ☐ Child Care Questions from Parent ☐ Child Care Provider Questions ☐ Health of Parent/Expectant Parent ☐ Lactation/Breastfeeding Questions/Support ☐ Parenting Questions/Concerns ☐ Prenatal Questions/Concerns ☐ Postpartum Questions/Concerns ☐ Substance Use/History ☐ Domestic Violence ☐ Homelessness/Unstable Housing ☐ Other: ☐ Franklin/GI Perinatal Team ☐ Perinatal Mental Health Counselor

C. ADDITIONAL COMMENTS, STRENGTHS, AND RESILIENCE FACTORS

D. REFERRAL SOURCE INFORMATION

Person Making Referral: Referral Date: - -
Agency/Organization: Phone: ( ) - ext:
Address: Email: Role:

E. MEDICAL PROVIDER INFORMATION (If different from Referral Source)

Provider Practice Name: Referral Date: - -
Provider/Physician Name: Phone: ( ) - ext:

Client Insurance: ☐ Medicaid/Dr. Dynasaur ☐ Private Insurance ☐ Uninsured ☐ Insurance Status Unknown
Medicaid ID#: Private Insurance Carrier:

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

For Internal Use Only:

Date Received: - - Received By: Date of Initial Contact: - -