



**CDS Central Referral Contact Information**  
 P: 877-770-8883  
 F: (207) 624-6661  
 W: <http://www.maine.gov/doe/cds/families/referrals>

**Child Find Intake Form**

\*Today's Date:

| Child Information (*required information)   |                |
|---|----------------|
| *Name   |                |
| *Date of Birth  | Age Today      |
| *Street Address   |                |
| *City, State, Zip   |                |
| *County   |                |
| *Gender   |                |
| *Child lives with   | (relationship) |
| Language spoken at home   |                |
| Interpreter needed? <input type="checkbox"/> Yes <input type="checkbox"/> No                                    |                |
| Does this child attend childcare/preschool? <input type="checkbox"/> Yes <input type="checkbox"/> No            |                |
| School name   | # days/wk      |
| Are any other agencies working with this child/family? <input type="checkbox"/> Yes <input type="checkbox"/> No |                |
| If so, please list:   |                |

| Primary Healthcare Provider |     |
|-----------------------------|-----|
| Physician's Name            |     |
| Practice Name               |     |
| Phone                       | Fax |

| Referral Information (*required information) |     |
|--|-----|
| Referral Source Name                         |     |
| Referral Source Agency                       |     |
| Phone  | Fax |
| Email  |     |
| *Relationship to the Child                   |     |
| *How did you hear about CDS?                 |     |
| *Reason for Referral                         |     |
| Diagnosis                                    |     |
| Explanation of Concern(s)                    |     |

| Parent or Guardian Contact Information (*required information)            |            |
|---|------------|
| This information is for the person(s) with whom the child resides.        |            |
| *Parent/Guardian #1 Name  |            |
| Relationship to the Child   |            |
| <input type="checkbox"/> Mailing address is the same address as the Child |            |
| Mailing Address   |            |
| City, State, Zip  |            |
| Preferred Phone   | Phone type |
| Other Phone   |            |
| Email   |            |
|   |            |
| Parent/Guardian #2 Name   |            |
| Relationship to the Child   |            |
| <input type="checkbox"/> Mailing address is the same address as the Child |            |
| Mailing Address   |            |
| City, State, Zip  |            |
| Preferred Phone   | Phone type |
| Other Phone   |            |
| Email   |            |

| Parent Restriction of Rights                  |  |
|---|--|
| <input type="checkbox"/> Mother is Restricted |  |
| Reason Right Restricted:                      |  |
|   |  |
| <input type="checkbox"/> Father is Restricted |  |
| Reason Right Restricted:                      |  |
|   |  |

| For CDS Use   |  |
|---|--|
| Referral Date   |  |
| Received by   |  |
| CDS Regional Site   |  |
| Child ID#   |  |
| Program <input type="checkbox"/> Early Intervention <input type="checkbox"/> Transition <input type="checkbox"/> ECSE |  |