child development services

**CDS Central Referral Contact Information**
P: 877-770-8883
F: (207) 624-6661
W: http://www.maine.gov/doe/cds/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? ☐ Yes ☐ No | |
| Does this child attend childcare/preschool? ☐ Yes ☐ No | |
| School name | # days/wk |
| Are any other agencies working with this child/family? ☐ Yes ☐ No | |
| If so, please list: | |

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

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

| **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 Restriction of Rights** |
|---|
| ☐ Mother is Restricted<br>Reason Right Restricted: |
| ☐ Father is Restricted<br>Reason Right Restricted: |

| **For CDS Use** |
|---|
| Referral Date |
| Received by |
| CDS Regional Site . |
| Child ID# |
| Program ☐ Early Intervention ☐ Transition ☐ ECSE |