



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	