Referral for Early Intervention Services

Please submit by Email to rthurston@communityhealthlink.org or dbergeron@communityhealthlink.org
or Fax to 978-840-9389

SERVING THE COMMUNITIES OF: ASHBY, BERLIN, BOLTON, CLINTON, DEVENS, FITCHBURG, GROTON, HARVARD, LANCASTER, LEOMINSTER, LUNENBURG, PEPPERELL, SHIRLEY, STERLING, TOWNSEND

Referral Information

***Referral Person/Agency**: _____ ***Phone**_____

***Reason(s) for Referral:**_____

***Family Aware of Referral: Yes___ No___ Unknown___ Comments:**_____

Child Information (child's legal name)

Last Name**:_____ First Name**: _____ **Middle Initial**: _____

***Birth Date**: _____ *** Referral Date**: _____ *** Sex**: M_____ F_____

***Street Address**:_____

City**: _____ ***Zip Code**: _____Primary Language:** _____

****Who has legal custody of this child? Parent:___ Relative: ___ DCF:___ Other:___ **NOTE TO DCF: IF DCF HAS LEGAL CUSTODY, PLEASE FAX A COPY OF THE MITTIMUS WITH THIS REFERRAL FORM.**

***Was this child previously enrolled in another EI Program? No___ Yes___ Name of Program:**_____

Parent/Guardian Information (with whom the child resides)

Last Name**: _____ First Name**: _____**Middle Initial:** _____

Relationship to Child**: _____Email Address (required for Telehealth)**:_____

***Street Address (If different from above)**_____

***Primary Language:** _____

***Primary Phone:** _____ Alternate **Phone:** _____

Last Name: _____**First Name**: _____ **Middle Initial:** _____

Relationship to Child: _____ **Email Address:**_____

Street Address (If different from above):_____

***Primary Language:** _____

Primary Phone: _____**Alternate Phone:**_____

Type of Insurance: _____ **Policy or ID Number:** _____

***Name of Pediatrician:** _____ **NPI#:**_____

Address: _____**Phone:** _____