

**DELAWARE COUNTY PUBLIC HEALTH SERVICES
EARLY INTERVENTION PROGRAM**

99 Main Street
Delhi, NY 13753
Office: 607-832-5200 Fax: 832-6022

DATE:

CHILD'S INFORMATION:

Name: _____

DOB: _____ Sex: M ___ F ___

Race: White ___ Black ___ Asian ___ American Indian/Alaskan ___
Native Hawaiian/Other Pacific Islander ___ Other ___ Unknown ___

Ethnicity Hispanic ___ Non-Hispanic ___ Unknown ___

PARENT/GUARDIAN INFORMATION:

Name: _____

Address _____

Phone: _____

REFERRAL SOURCE:

Name: _____ Phone: _____

REASON FOR REFERRAL: (Please check one – attach additional sheets when appropriate)

___ Indicated CPS Report

___ At risk of having a developmental delay or disability

___ Suspected of having a developmental delay or disability

Other _____