Region 5 Infant Toddler Program

Infant Toddler Program Referral

Child Information		
Name	Child's Address	SS #: DOB:
Is the child currently enrolled in Medicaid/Insurance ☐ Yes ☐ No		
Gender: ☐ Male ☐ Female	Language: ☐ English ☐ Spanish ☐ Other _____	

Parent/Guardian Information (Specify Mother, Father, Foster Parent, other Guardian)		
Name	Address	Phone Day: Evening:

Other Contacts		
Physician		

Referral Information		
Person Making Referral	Relationship to Child	Phone
List other services/referrals provided to child		
History/Information about child/family or area of concern:		

CONSENT FOR REFERRAL

It is the goal of the Infant Toddler Program to involve the family at all levels of decision making. You will be provided a copy of your rights as a parent in the Infant Toddler Program. An explanation of the rights is available in your native language. By Signing this consent, you are allowing this agency to contact the Infant Toddler Program and supply the Infant Toddler Program information listed above.

_____ Parent/Guardian Signature/ Date

_____ Parent/Guardian Signature/ Date

REFERRALS CAN BE FAXED TO (208) 736-2135 ATTN: INFANT TODDLER PROGRAM

For questions or specific follow up, please contact 736-2182 and ask to speak to a supervisor to discuss the referral further

IDAHO DEPARTMENT OF HEALTH & WELFARE