SOUTH CENTRAL LOS ANGELES REGIONAL CENTER
FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

EARLY START INTAKE UNIT REFERRAL FORM

Child's Information: **Date:**

First Name:	**Middle Name:**	**Last Name:**
Date of Birth:	**Age:**	**Ethnicity:** Select Ethnicity
Gender: Select Gender	**Language Spoken at Home:** Select Language	**Preferred Communication Language:** Select Language

Information for Adult Responsible for Child:

First Name:	**Last Name:**	**Relationship to Child:**
Address:	**City:**	**ZIP Code:**
Primary Phone:	**Alternate Phone**	**Email:**
Gender: Select Gender	**Language Spoken at Home:** Select Language	**Preferred Communication Language:** Select Language

Information for Person Making the Referral: **Agency:**

First Name:	**Last Name:**	**Title:**
Phone Number:	**Fax Number:**	**Email:**

DCFS Social Worker Information:

First Name:	**Last Name:**	**Social Worker ID #:**
Phone Number:	**Fax Number:**	**Email:**

Has the child previously received an assessment or services from South Central Los Angeles Regional Center OR another Regional Center??

☐ **Yes** ☐ **No**

If yes, please name the Regional Center: Select RC **UCI #:**

Please describe your concerns regarding the child's development and any medical conditions:

Referral form and medical records may be faxed to (213) 947-4115, or emailed to earlystartintake@sclarc.org. If you wish to speak with an Early Start Intake Assistant, please contact Marizela De La Rosa at (213) 744-8807, or Sofia Wilson at (213) 744-8809.

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