



# ECDP REFERRAL FORM

95 Mahalani St., Wailuku, Maui, HI 96793  
(808) 244-7467 Fax (808) 242-4762

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Male  Female Age: \_\_\_\_\_ Ethnicities: \_\_\_\_\_

## LEGAL GUARDIANSHIP

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship: \_\_\_\_\_ Ethnicities: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ ( ) Secondary: \_\_\_\_\_ ( ) Other Phone: \_\_\_\_\_ ( )

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship: \_\_\_\_\_ Ethnicities: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ ( ) Secondary: \_\_\_\_\_ ( ) Other Phone: \_\_\_\_\_ ( )

Address: \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Primary Language(s) child: \_\_\_\_\_ parent: \_\_\_\_\_ Interpreter needed?  No  Yes

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

## MEDICAL INSURANCE \*\*\* PLEASE ATTACH COPY OF MEDICAL CARD(S) \*\*\*

Subscriber's Name: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_ Subscriber ID #: \_\_\_\_\_

Secondary Provider: \_\_\_\_\_ Subscriber ID #: \_\_\_\_\_

Primary Care Provider / Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_

Concern(s): \_\_\_\_\_

## PARTNER AGENCIES INVOLVED W/ CHILD

CWS Caseworker: \_\_\_\_\_ Phone: \_\_\_\_\_  Voluntary  Involuntary  N/A

MFSS:  Enhanced Healthy Start  Early Head Start  PHN  WIC  OTHER: \_\_\_\_\_

Preschool: Name & Days/Times Attending: \_\_\_\_\_

Daycare Name & Days/Times Attending: \_\_\_\_\_

## REFERRAL SOURCE

Referral Source (print name) \_\_\_\_\_ Phone: \_\_\_\_\_ (if not listed above)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_