Exceptional Family Resource Center

A Center for Families of Children with Developmental Disabilities

A 501 © 3 Not-for-Profit Public Charitable Organization

Early Start Referral Form

Child's Information

First Name________________ Middle_________________ Last Name___________________

D.O.B: _______________ Age: ________________ Ethnicity: _____________________

Gender (M/F)______________ Language:____________ Diagnosis:______________________

Information about adult responsible for child.

First Name_________________ Last Name_________________ Relationship______________

Address: ____

City _____________________ State______________________ Zip Code__________________

Primary Phone Number: ___________________________ Cell: __________________________

Referral Source

Name: ______________________________ Agency______________________________________

Phone Number: _____________________ Email:_______________________________________

Referral Date: ____

You may scan and e-mail, fax, mail, or drop-off referral forms to our office:

3121 N. Sillect Avenue, Suite 303
Office: 661-873-4973/ Fax: 661-873-4978
*Please scan and e-mail all forms to v.gantong@kernefc.org

Confidential Client Information
California Welfare & Institutions Code, Section 4514