FIT Referral

Please return this form within two working days of identifying a child in need of developmental assessment.

Family Infant Toddler Program
P.O. Box 528, Bethel, AK 99559 Phone: 907-543-3690 Fax: 907-543-1276

MR#: ______________________________ Today's Date: ______________

Child's Name: ______________________________ Date of Birth: ______________

Medicaid/Denali: ______________________________ Other Insurance: ______________________

ID#: ______________ Group #: __________ Ins. Co. Phone: ______________________

Caregiver Name: ____________________ Relationship: ______________ Phone #: ______________

Other Caregiver Name: ____________________ Relationship: ______________ Phone #: ______________

Additional contact name: ______________________________ Phone: ______________

Mailing Address/P.O. Box: ____________________ Community: ____________________ Zip: ________

Gestational Age: ____________ Gestational Weight: ______________

Referred by: ______________________________ Is caregiver informed of referral? Yes No

CAPTA OSC Worker: ______________________________ Phone: ______________

OPT-OUT FOR EED NOTIFICATION (24 months plus at enrollment)

Who can sign paperwork for this child? ______________________________

Primary language: ______________________

Reason for referral and observations of the child:

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For Office Use Only

Date entered in database: __________ 45 day deadline ____________ Interventionist: ______________________