

**Developmental Screening and Support for Infants and Toddlers (Waukesha County Residents Only)**

**Phone: 262-548-7212**

**Fax: 262-896-8367**

Date of Inquiry: \_\_\_\_\_ Individual Calling/Faxing: \_\_\_\_\_

Child's Last Name: \_\_\_\_\_ Child's First Name: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_ Sex: **M** **F**

Home Phone: \_\_\_\_\_ Additional Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Child's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Family/Child Insurance Carrier: \_\_\_\_\_

**Areas of Concern/Reason for Calling:** \_\_\_\_\_

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Substantiated CA/N:      **No**      **Yes**      CW/CPS Referral      **No**      **Yes**

Additional Comments: \_\_\_\_\_

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Referral Taker: \_\_\_\_\_

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Internal Information only:

Date Received: \_\_\_\_\_