South Central Los Angeles Regional Center
2500 S. Western Ave., Los Angeles, CA 90018

Early Start Intake Unit Referral Form

Child's Information: Date: ________________________________

First Name	Middle Name	Last Name

Date of Birth	Age	Ethnicity

Gender (male or female)	Language

Information for adult responsible for child:

First Name	Last Name	Relationship (mother, father, legal guardian, foster parent)

Street Address

City	State	Zip Code

Primary Phone Number	Cell Number	Alternate Phone Number

DCFS social worker name (for DCFS cases)	Phone number	Fax number

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:_______________________________________ UCI# ________________________

In the box below, 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 . 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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