For Office Use Only:
Referral ID # _____ 45 Day Time Line: _____
Child ID # _____ Interim S.C.: _____
Date Entered Into Database _____
Home School: _____

GARRETT COUNTY
INFANTS AND TODDLERS PROGRAM
Referral

PLEASE PRINT

Today's Date _____
Your Name _____
Agency / Title _____ Your Phone Number _____
Who suggested you contact us? _____

How did you learn about I&T program? (Select all that apply)
Brochure ___ Doctor ___ Radio ___ Nurse ___ Prior Experience ___ Relative ___ Newspaper ___ Theater ___
Other Agency: _____ Other: _____

Individual Information

Name of Child _____
(First) (Middle) (Last)
Birth Date: _____ Race: _____ Gender: _____

Birth Weight _____ Gestational Age _____

Parent / Guardian: _____

Address: _____

Home Phone: _____ Daytime/ Work Phone: _____

Contact Person _____ Phone: _____
(If no phone in home)
Describe concerns in detail: _____

Family Notified of Referral: _____ Yes _____ No

Please submit referral by mail, phone or fax:
Garrett County Infants and Toddlers Program
345 Oakland Drive
Oakland, Maryland 21550
Phone: 301-533-0240 Fax: 301-334-7978