

**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	Name of person/agency making referral and phone #

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 someone about your referral, please contact Veronica Becerra at (213) 744-7068, Marizela De La Rosa at (213) 744-8807, or Sofia Wilson at (213) 744-8809.