Golden Gate Regional Center

Early Start Referral Form (Age 0 to 36 months)

Submit Form and Related Records to

Email: intake@ggrc.org Fax: 1-888-339-3306

☐ San Francisco County ☐ Marin County ☐ San Mateo County

Form completed by: ☐ Parent ☐ Medical Provider ☐ Other (specify): _____

(*) Required Information

*Child's LAST Name | *Child's FIRST Name

*Child's Date of Birth | Child's Gender | Child's Ethnicity | Language

Referring Agency/Organization | Name | Email | DIRECT Phone

Street | City | State | Zip

*Physical Address of Child:

Mailing Address (If Different)

Physical address applies to: ☐ Father ☐ Mother ☐ Other Legal (e.g. resource/foster home: additional details below) ☐ check if transient (please identify an address, such as a shelter, relative's home, etc.)

Contact Information | Name (Last, First) | Phone | Email

*Parent

Parent

Other Legal to Contact
(e.g. resource/foster parent)

Legal Representative or Educational Rights Holder (e.g., CPS, CASA, grandparent, etc.) if applicable.
Please include copy of court orders naming this legal party.

Full Name: | Relationship:

Phone: | Email:

Developmental Concerns

Please attach any pertinent medical or developmental reports and describe concerns below

Cognitive:

Physical/Motor:

Vision/Hearing:

Communication:

Social/Emotional

Adaptive/Self-Help:

☐ Check if child has an Established Risk (specific diagnosis) or is High Risk. Must include medical records.

GGRC Use Only
Date Received: | 45 Day: | Age/Mo: | UCI: