☐ **ENGLISH**

☐ **SPANISH**

North Bay Regional Center

Intake Department

Community Referral Form

Applicant's Name: _____ **Date of Birth:** _____
(Must be over age 3)

When referring individuals 3 years or older for North Bay Regional Center (NBRC) services, there must be a suspicion of a developmental disability as outlined below.

Please identify the condition(s) and list your concerns commenting on all pertinent areas:

☐ **EPILEPSY** ☐ **CEREBRAL PALSY** ☐ **AUTISM**

☐ **INTELLECTUAL DISABILITY** (or conditions closely related or require similar treatment to intellectual disability)

(1) Communication: _____

_____

(2) Social-emotional: _____

_____

(3) Learning/cognition: _____

_____

(4) Repetitive behaviors/restricted interests: _____

_____

(5) Other concerning behaviors: _____

_____

(6) Daily living: _____

_____

(7) Seizure type and frequency (if applicable): _____

PLEASE SEND ALL RELEVANT DOCUMENTATION TO HELP ASSESS FOR ELIGIBILITY

Form Completed By: _____ Date: _____

Fax this form to Intake Dept: (707) 260-6269 OR Email to: LaurieA@nbrc.net

For Parent/Applicant use only

☐ I would like to be contacted NBRC's Intake Department to complete a referral for services

Name: _____ Signature: _____

Relationship to applicant: _____ Phone #: _____