Tanana Chiefs Conference Infant Learning Program

REFERRAL FORM

Today's Date: _____

Child's Name: _____ **Date of Birth:** _____

Gender: Male☐ Female☐ Insurance ID #:_____

Child lives with: _____

Parent/Guardian Information:

Name:_____

Mailing Address: _____

Physical Address: _____

Telephone: _____

Email Address: _____

Reason for Referral: _____

Referral Notes (please include any important medical information):

_____

_____

_____

Parent has been notified that a referral has been made: Yes ☐

Referral Source: _____

Referral Contact Phone: _____

Please fax this form to:
TCC Infant Learning Program: (907) 459-3952
OR
Mail to:
TCC Infant Learning Program
122 First Ave, Ste. 600
Fairbanks, AK 99701

Program use only: Follow up with Referral Source Contacted Family__/__/__

45 Day__/__/__ Letter__ Email__ Fax__ Phone__ FSC_____

(2/14)