



Behavioral
Health
Division

Early Intervention & Education Program: Part C

Referral Form

Fax completed form to 307-777-5580 or email to wdh-eiep-program@wyo.gov:

Referring Agency/Person:

Child's Name:

DOB:

Initial Referral

Date: _____

Parent name, address, phone #:

45 Day deadline:

Interpreter Needed: Yes _____ No _____

Text acceptable: Yes _____ No _____

Reason for referral:

Other agencies involved/additional information: _____

Child's Medical home:

Family Service Coordinator Assigned:

Evaluation Date:

Intake Sent:

Evaluation Location:

Medicaid Number (if applicable):