



Pediatrician's Referral to RCEB For Children Over Age 3

Persons who are eligible for our services over the age of 3 are persons with a developmental disability, defined as mental retardation, cerebral palsy, epilepsy, autism, or other conditions closely related to mental retardation or requiring treatment similar to that required by persons with mental retardation. The condition must constitute a substantial disability, defined as significant functional limitations in three or more areas of major life activity, as determined by a regional center and as appropriate to the age of the person: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; and economic self-sufficiency.

To refer a child over 3, provide the family with our Intake Number (510) 383-1312

OR

After obtaining the consent required below, complete this form and fax to:

ATTENTION: INTAKE COORDINATOR/OVER 3 (510) 633-5022

CONSENT: Verbal or written consent by Parent / Legal Guardian is required prior to this referral.
Referral cannot be processed if this is not completed.

1. _____ Verbal consent has been obtained from parent / legal guardian for referral of child to Regional Center of the East Bay
OR
2. _____ I hereby give consent for my child to be referred to Regional Center of the East Bay (RCEB) I also consent to the exchange of verbal or written information between qualified professionals from RCEB and my child's pediatrician

Parent / Legal Guardian Signature _____ Date _____

Child's Name _____ **D.O.B.** _____

Parent/Legal Guardian's Name _____

Address _____

City _____ **Zip** _____ **Phone Numbers (Home)** _____

Email _____ **(Cell or Work)** _____

Pediatrician's Name _____ **Phone Number** _____

Address _____

City _____ **Zip** _____ **E-mail** _____

REASON FOR REFERRAL (see above for eligible developmental disabilities)

Other Information
