Down Syndrome Indiana™

Inquiries and Referrals Form

Email to: lisa@dsindiana.org
Fax to: 317-925-7619

Requested by: _____

Last Name _____ First Name _____

Address_____

City_____ State_____ Zip Code_____

Email_____

Preferred Phone _____

Relationship to individual with D/s: (please circle all that apply)

Parent Healthcare Professional Grandparent Educator

Individual with D/s Sibling Other:_____

Name of person who has Down syndrome _____

Date of birth _____ Hospital _____

Pediatrician's Name and contact information _____

Particular health issues_____

General Topic (in 3 words or less) _____

Describe the nature of the call and action needed:

_____

_____

_____

_____

_____

_____

_____

How did you Hear about Down Syndrome Indiana?

____ Buddy Walk®

____ DSI Website;

____ Community Group; Please specify which one:
_____
_____

____ Referred by someone; Please tell us who to thank:
_____
_____

____ Exhibit;

____ DSI Event; Please tell us what event:
_____
_____

____ 211;

____ Picked up Literature;

____ Riley Children's Hospital;

____ St. Vincent's;

____ New Parent Packet;

____ Other - Please Specify:
_____
_____

Staff use only:

___ Date and time received: _____ Initial: _ ___
___ Fill out Database Add Form and give to Member Services. Initial: ____
___ Date completed: _____ # of business days: _____ Initial: _____
___ Date of follow up: _____ Initial: _____
___ Check here when complete. Initial: _____

Last updated on: June 30, 2015