

Referral/Release Form

The North Carolina Down Syndrome Alliance (NCDSA) exists to empower, connect, and support the lifespan of individuals with Down syndrome, their families, and the community through outreach, advocacy, and education throughout North Carolina. NCDSA is an effective, compassionate, and comprehensive resource on Down syndrome.

Due to privacy concerns, your healthcare provider cannot share your contact information with NCDSA without your permission. If you would like to connect with us, please complete the following information:

I grant permission to _____ to release my name, address, phone number, and due date/date of birth to the North Carolina Down Syndrome Alliance.

Signature: _____ Date: _____

Mother's Name: _____ Father's Name: _____

Address (street): _____

City, State, Zip: _____ County: _____

Phone: _____

Mother's E-mail: _____ Father's E-mail: _____

Which race or ethnicity best describes the parents?

- | | | |
|--|---|---|
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Black or African American |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> Multiple Ethnicity/Other _____ |

I hereby release _____, NCDSA and their employees from any and all liability for any and all such claims or damages which may at any time result on account of compliance with this authorization. I also acknowledge that I am the parent or legal guardian of this child.

How can NCDSA support you?

- | | |
|---|--|
| <input type="checkbox"/> I recently received a prenatal diagnosis | <input type="checkbox"/> I would like a prenatal packet |
| <input type="checkbox"/> I recently received a postnatal/birth diagnosis | <input type="checkbox"/> I would like a Welcome Baby Bag |
| <input type="checkbox"/> I would like to be connected to a Trained Mentor | <input type="checkbox"/> Connect me with a Spanish speaking parent |
| <input type="checkbox"/> I am in the process of adopting a baby/child with Ds | <input type="checkbox"/> My family would like to be connected to NCDSA |
| <input type="checkbox"/> My family is new to the area | <input type="checkbox"/> I would like to receive e-newsletter |

Child's name: _____ Child's date of birth/due date: _____ Sex: M / F

PROVIDER: Please send completed form to NCDSA by faxing to (919) 788-3646 or emailing to info@ncdsalliance.org.