Early Intervention Program Referral Form

Anyone can use this form to refer a child to Early Intervention (EI). • Parents are encouraged to call 311 and ask for **Early Intervention** to make referrals. • EI service providers must use the New York Early Intervention System (NYEIS) to make referrals. • Administration for Children's Services (ACS) employees and agencies contracted with ACS must call the Citywide ACS Referral Hotline at 877-885-KIDZ (877-885-5439) to make referrals.

1. REQUIRED INFORMATION

Referral source

Name: | Referral Date: *(MM/DD/YY)* ___/___/___

Agency/Facility (if any):

Phone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ | Fax: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Address: | City: | State: | Zip Code: ___ ___ ___ ___ ___

Referral Source Type: ☐ Parent/Family ☐ Pediatrician/Doctor ☐ Hospital ☐Community Program ☐ Department of Homeless Services/Shelter Staff ☐ Other: _____

Child Info

Child's Name: *(Last, First)* | **Date of Birth:** *(MM/DD/YY)* ___/___/___

Race (may select more than one): ☐ White ☐ Black ☐ Asian ☐ Native American/Alaskan ☐ Hawaiian or Pacific Islander

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Gender: ☐Male ☐ Female

Municipality of Residence (Borough): | **Dominant Language*:**

Family and Contact Info

Mother's Name: *(Last, First, Middle)*

_____

Date of Birth: __ __/__ __/__ __

Dominant Language*: _____

English proficient**? ☐ **YES** ☐ **NO**

Father's Name: *(Last, First, Middle)*

_____

Date of Birth: __ __/__ __/__ __

Dominant Language*: _____

English proficient**? ☐ **YES** ☐ **NO**

Alternate Caregiver Contact Name: _____

Relation to Child: ☐ Grandparent ☐ Foster Parent ☐ Other: _____

Dominant Language*: _____

English proficient**? ☐ **YES** ☐ **NO**

Phone: (__ __ __) __ __ __- __ __ __ __

Address:

City: **State:** **ZIP Code:** __ __ __ __ __

Telephone:

Cell (__ __ __) __ __ __- __ __ __ __

Home (__ __ __) __ __ __- __ __ __ __

Work (__ __ __) __ __ __- __ __ __ __

Select Only One

REASON FOR REFERRAL

☐ **EARLY INTERVENTION:** Child with a suspected or known developmental delay or disability. **Fax to the EIP Regional Office in the child's borough of residence:**
Brooklyn: 347-396-8817
Manhattan: 212-436-0902 **Queens:** 718-553-3997
Staten Island: 718-568-2341 **Bronx:** 718-838-6862

☐ **DEVELOPMENTAL MONITORING:** Child is developing typically but may be "at risk" for atypical development, *or* child missed or failed newborn hearing screening.

Fax to the Citywide Developmental Monitoring Office: **347-396-8869**

2. INFORMED PARENT/GUARDIAN CONSENT REQUIRED

Suspected of Delay Primary Referral Reason (EI):
☐ Adaptive ☐ Cognitive ☐ Communication ☐ Physical ☐ Social/Emotional ☐ Diagnosis: _____
Other concerns: _____

At Risk of Delay Referral Reason (DM):
☐ Birth weight: 1,000 – 1,500 grams ☐ NICU stay: 10 days or more ☐ Parental drug/alcohol misuse ☐ Other (see instructions): _____

Child Known to ACS: ☐Yes ☐ No

Child in a Health Home: ☐Yes ☐ No Care Management Agency :_____
Care Manager: _____ Phone: (__ __ __) __ __ __- __ __ __ __

Child's Doctor: | **Doctor's Phone:** (__ __ __) __ __ __- __ __ __ __

Birth Hospital: | **Location:**

Birth Weight: *Pounds:* __ __ *Ounces:* __ __ ***or*** *Grams:* __ __ __ __ **Gestational Age**: __ __ *weeks*

3. REQUIRES PARENT/GUARDIAN SIGNATURE

Parental Consent to Share and Release Information

I authorize the Early Intervention Program to share: ☐ the name and contact information of my service coordinator ☐ the multidisciplinary evaluation (MDE) ☐ information about my child's service plan ☐ service providers assigned to my case with the individuals listed below.

☐ Primary Care Provider: _____ share info via: ☐ Fax: (__ __ __) __ __ __- __ __ __ __
☐ Health Commerce System (HCS) User ID: __ __ __ __ __ __ ☐ Mailing Address: _____
☐ Other, specify (i.e., Case Worker) _____ share info via: ☐ Phone: (__ __ __) __ __ __- __ __ __ __
☐ Fax: (__ __ __) __ __ __- __ __ __ __ ☐ Mailing Address:_____

Parent Signature: _____ **Date:** _____

Questions? Call 311 and ask for "Early Intervention." **EIP 11/2020**

*The language that the child uses the most. **Can the parent communicate in English?