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

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 ☐ Other:

Municipality of Residence (Borough): _______

Mother’s Name: (Last, First, Middle) ____________________

Father’s Name: (Last, First, Middle)____________________

Alternate Caregiver Contact Name: ______________________

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

Dominant Language*:

English proficient**? ☐ YES ☐ NO

Dominant Language*:

English proficient**? ☐ YES ☐ NO

2. INFORMED PARENT/GUARDIAN CONSENT COMPLETE

Select Only One

☐ 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:

Queens: 718-553-3997  Brooklyn: 718-722-2998

Manhattan: 212-436-0902  Bronx: 718-838-6862

Staten Island: 718-568-2341

☐ 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

Suspected of Delay Primary Referral Reason (EI):

☐ Adaptive ☐ Cognitive ☐ Communication ☐ Physical ☐ Social/Emotional ☐ Diagnosis: ____________________________

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):

Other concerns: ____________________________

Child Known to ACS: ☐ Yes ☐ No

Care Manager: ____________________________ Phone: (___ ___) _______ _______ _______

Child in a Health Home: ☐ Yes ☐ No

Care Manager: ____________________________ Phone: (___ ___) _______ _______ _______

Child’s Doctor:

Doctor’s Phone: (___ ___) _______ _______ _______

Birth Hospital: ____________________________

Location:

Birth Weight: Pounds: ______ Ounces: ______ or Grams: __________ Gestational Age: ______ weeks

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: ____________________________ share info via: ☐ Fax: (___ ___) _______ _______ _______

☐ Other, specify (i.e., Case Worker) ____________________________ share info via: ☐ Phone: (___ ___) _______ _______ _______

Fax: (___ ___) _______ _______ _______ ☐ Mailing Address:

3. REQUIRE PARENT/GUARDIAN SIGNATURE

Parental Consent to Share and Release Information

Parent Signature: _______ Date: _______

Questions? Call 311 and ask for “Early Intervention.”

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