



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) ____ / ____ / ____		
	Child Info	Agency/Facility (if any): _____		Phone: (____) _____ - _____ Fax: (____) _____ - _____		
		Address: _____		City: _____	State: _____	Zip Code: _____
		Referral Source Type: <input type="checkbox"/> Parent/Family <input type="checkbox"/> Pediatrician/Doctor <input type="checkbox"/> Hospital <input type="checkbox"/> Community Program <input type="checkbox"/> Department of Homeless Services/Shelter Staff <input type="checkbox"/> Other: _____				
Family and Contact Info	Child's Name: (Last, First) _____		Date of Birth: (MM/DD/YY) ____ / ____ / ____			
	Race (may select more than one): <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native American/Alaskan <input type="checkbox"/> Hawaiian or Pacific Islander		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
	Municipality of Residence (Borough): _____		Dominant Language*: _____			
	Mother's Name: (Last, First, Middle) _____		Father's Name: (Last, First, Middle) _____		Alternate Caregiver Contact Name: _____	
Select Only One	Date of Birth: ____ / ____ / ____		Date of Birth: ____ / ____ / ____		Relation to Child: <input type="checkbox"/> Grandparent	
	Dominant Language*: _____		Dominant Language*: _____		<input type="checkbox"/> Foster Parent <input type="checkbox"/> Other: _____	
	English proficient**? <input type="checkbox"/> YES <input type="checkbox"/> NO		English proficient**? <input type="checkbox"/> YES <input type="checkbox"/> NO		Dominant Language*: English proficient**? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	Phone: (____) _____ - _____		Address: _____			
2. INFORMED PARENT/GUARDIAN CONSENT REQUIRED	City: _____		State: _____		ZIP Code: _____	
	Telephone: _____		Cell (____) _____ - _____			
	Home (____) _____ - _____		Work (____) _____ - _____			
	REASON FOR REFERRAL					
3. REQUIRES PARENT/GUARDIAN SIGNATURE	<input type="checkbox"/> EARLY INTERVENTION: Child with a <u>suspected or known developmental delay or disability</u> . Fax to the EIP Regional Office in the child's borough of residence: Brooklyn: 718-722-2998 or 718-722-2996 Manhattan: 212-436-0902 Queens: 718-553-3997 Staten Island: 718-568-2341 Bronx: 718-838-6862			<input type="checkbox"/> DEVELOPMENTAL MONITORING: Child is developing typically but may be "at risk" for <u>atypical development, or child missed or failed newborn hearing screening</u> . Fax to the Citywide Developmental Monitoring Office: 347-396-8869		
	<input type="checkbox"/> Suspected of Delay Primary Referral Reason (EI): <input type="checkbox"/> Adaptive <input type="checkbox"/> Cognitive <input type="checkbox"/> Communication <input type="checkbox"/> Physical <input type="checkbox"/> Social/Emotional <input type="checkbox"/> Diagnosis: _____ Other concerns: _____			<input type="checkbox"/> At Risk of Delay Referral Reason (DM): <input type="checkbox"/> Birth weight: 1,000 – 1,500 grams <input type="checkbox"/> NICU stay: 10 days or more <input type="checkbox"/> Parental drug/alcohol misuse <input type="checkbox"/> Other (see instructions): _____		
	Child Known to ACS: <input type="checkbox"/> Yes <input type="checkbox"/> No		Child in a Health Home: <input type="checkbox"/> Yes <input type="checkbox"/> 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						
Parental Consent to Share and Release Information						
I authorize the Early Intervention Program to share: <input type="checkbox"/> the name and contact information of my service coordinator <input type="checkbox"/> the multidisciplinary evaluation (MDE) <input type="checkbox"/> information about my child's service plan <input type="checkbox"/> service providers assigned to my case with the individuals listed below.						
<input type="checkbox"/> Primary Care Provider: _____ share info via: <input type="checkbox"/> Fax: (____) _____ - _____ <input type="checkbox"/> Health Commerce System (HCS) User ID: _____ <input type="checkbox"/> Mailing Address: _____ <input type="checkbox"/> Other, specify (i.e., Case Worker) _____ share info via: <input type="checkbox"/> Phone: (____) _____ - _____ <input type="checkbox"/> Fax: (____) _____ - _____ <input type="checkbox"/> Mailing Address: _____						
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?