Early Intervention Program Referral Form

Anyone can use this form to refer a child to Early Intervention (EI). • Parents or guardians 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 877-855-KIDZ (877-855-5439) 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/Guardian/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 EI Program Regional Office in the child's borough of residence:**

Queens: **718-553-3997**	Brooklyn: **718-722-2998**
Manhattan: **212-436-0902**	Bronx: **718-410-4504**
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**

2. INFORMED PARENT/GUARDIAN CONSENT REQUIRED to complete

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

Parent/Guardian 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/Guardian Signature: _____ **Date:** _____

Questions? Call 311 and ask for "Early Intervention." **EIP 6/2018**

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

Instructions for Completion: Early Intervention Program Referral Form
(DO NOT FAX WITH THE REFERRAL FORM)

Anyone can use the New York City Early Intervention (EI) Program Referral Form to refer a child to the EI program.

- Parents or guardians 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 877-855-KIDZ (877-855-5439) to make referrals.

This referral form is divided into three sections:

Section 1: Required Information: This section is required and must be filled out completely for the referral to be accepted by EI. You do not need parent/guardian consent to submit the information in this section. However, providers should speak with the family and explain EI before making a referral. **Families have the right to refuse to participate in EI.**

Section 2: Informed Parent/Guardian Consent Required to Complete: You can only share information in this section if you receive verbal consent from parents or guardians.

Section 3: Requires a Parent/Guardian Signature: This section can only be completed with a parent's or guardian's written consent – a signature is required. **Families who are not in stable housing or who do not have consistent access to a telephone should complete Section 3. This allows the EI program to communicate and share information with case workers and other professionals assigned to the family, and to make sure the family receives the needed EI services.**

Notes:

- Although Sections 2 and 3 are not required, the information will help the EI program assign a Service Coordinator.
- For questions about completing the form or making a referral, call 311 and ask for **Early Intervention**.
- The phrase "dominant language" means the language that the parent/guardian or child uses the most, and the phrase "English proficient" means that the parent/guardian communicates well in English.

Section 1: Required Information

1. **Referral Source:** Write the name, agency or facility (if applicable), address, telephone, and fax numbers of the person making the referral. Check the appropriate box to identify the Referral Source Type.
2. **Child Info:** Write the child's full name. Provide the child's date of birth in a two-digit month, day and year format (e.g., 03/25/18). Check the box to identify the child's race, ethnicity and gender. Indicate the borough of residence and the language the child uses the most.
3. **Family and Contact Info:**
   - Write the name of the child's biological/adoptive mother (if applicable), last name first. Include their date of birth, dominant language and whether they can communicate well in English.
   - Write the name of the child's biological/adoptive father (if applicable), last name first. Include their date of birth, dominant language and whether they are proficient in English.
   - Write the name of an alternate caregiver (if applicable) and check the box to indicate the relationship to the child. Indicate their dominant language and whether they are proficient in English. Provide a contact number.
   - Write the full address where the child resides, including the city (borough) and ZIP code. To the right, write the family's telephone numbers.
4. **Reason for Referral:** Check the box for Early Intervention or Developmental Monitoring (DM). **See the Appendix for additional information.**

Section 2: Informed Parent/Guardian Consent Required to Complete

1. **Suspected of Delay Primary Reason (EI):** If the child is being referred to EI, check the boxes to indicate the areas of development in which there are concerns. Provide the DSM-V diagnosis (if applicable) and other concerns.
2. **At Risk of Delay Referral Reason (DM):** If the child is being referred to DM, check the box for the appropriate risk factors. If the risk factor is not listed, choose from the risk factors in the **Appendix**.
3. **Child Known to ACS**: Check the appropriate box to indicate if the family is known to ACS.
4. **Child in a Health Home:** Indicate whether the child is in a Health Home. If so, indicate the Care Management Agency name, the name of the care manager and their phone number.
5. **Child's Doctor**: Write the name of the child's primary health care provider and their phone number.
6. **Birth Hospital**: Write the name and location of the hospital in which the child was born.
7. **Birth Weight:** Write the child's birth weight in pounds and ounces, or in grams. Include the gestational age, if known.

Section 3: Requires Parent/Guardian Signature

1. **Parent/Guardian Consent to Share and Release Information**: Check the appropriate boxes to identify the information that the parent/guardian would like to share with people outside of the EI program.

2. If the parent/guardian agrees to share information, indicate the names of the people they would like to share information with and how the information should be shared. **The parent/guardian must sign and date this section of the form.**

Appendix – Reason for Referral Clarification

Section 1 contains the **REASON FOR REFERRAL** block. The individual referring the child must indicate if the child is being referred to the EI Program Regional Office in the child's borough of residence, **or** is being referred to Developmental Monitoring (DM). Use the information below to decide which **REASON FOR REFERRAL** box to check and where to send the referral.

EARLY INTERVENTION: Child with a suspected or known developmental delay or disability.
This referral is sent to the EI Program Regional Office in the child's borough of residence for a multidisciplinary evaluation (MDE). Check this box if:

- The child has suspected or known developmental delays and/or a diagnosed physical or mental condition with a high probability of a future developmental delay.
- The child has a condition likely to lead to a developmental delay, such as Down syndrome; a birth weight less than 1,000 grams (2.2 pounds); failure of two (2) hearing screenings; or confirmed hearing or vision loss.
- The results of a developmental screening or diagnostic procedure, direct experience, observation and perception of the child's developmental progress show that the child is not developing similarly to their peers.
- The parent or guardian is requesting an evaluation or has provided information that indicates the possibility of a developmental delay or disability.

DEVELOPMENTAL MONITORING: Child is developing typically but may be at risk for atypical development.
This referral is sent to the Citywide Developmental Monitoring Office for ongoing screening using the Ages and Stages Questionnaires®. Check this box if:

- The child is developing typically but may be at risk for atypical development.
- The child missed or failed a newborn hearing screening or rescreening (not rescreened within 75 days).
- The child meets one or more of the risk factors outlined below.

Developmental Monitoring Risk Factors

Neonatal Risk Criteria	Post-Neonatal Risk Criteria	Other Risk Criteria
• Birth weight 1,000–1,500 grams • Gestational age less than 33 weeks • NICU stay of ten (10) days or more • CNS insult or abnormality • Asphyxia, defined as Apgar score of 3 or less at five minutes • Growth deficiency or nutrition problems (e.g., SGA) • Presence of inborn metabolic disorder • Maternal prenatal alcohol or illicit substances misuse • Congenital malformations • Hypertonicity or hypotonicity • Hyperbilirubinemia (above 20 mg/dl) • Hypoglycemia (serum glucose less than 20 mg/dl) • Prenatal exposure to therapeutic drugs with known risk • Venous blood lead level greater than 19 mcg/dl • HIV infection • Maternal PKU	• Parental developmental disability or mental Illness • Suspected or family history of hearing impairment • Suspected or family history of vision impairment • Other risk criteria identified by referral source (describe) • Parent/guardian concern regarding development • Questionable score on developmental or sensory screen • Illness or trauma with CNS implications and in PICU ten (10) days or more • Serous otitis media continuous for at least three (3) months • Growth deficiency or nutritional problems, failure to thrive, or iron deficiency	• No prenatal care • Homelessness • History of child abuse or neglect***** • No well child care visit by age six (6) months • Concern regarding parenting due to poor bonding or impairment in psychological or interpersonal functioning • Significant immunization delay • Parental alcohol or illicit substance misuse • Perinatal or congenital transmission of infection (e.g., HIV, hepatitis B, syphilis) • Other risk criteria identified by referral source *Referrals of typically developing children in ACS foster care who have not been screened for development should be sent to DM.