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.

**Name:**
**Agency/Facility (if any):**
**Phone:** ( )
Fax: ( )
**Address:**
City: State: Zip Code:

**Referral Source:**
- Parent/Family
- Pediatrician/Doctor
- Hospital
- Community Program
- Department of Homeless Services/Shelter Staff
- Other:

**Child Info:**
- **Child’s Name:** (Last, First)
- **Race (may select more than one):** □ White □ Black □ Asian □ Native American/Alaskan □ Hawaiian or Pacific Islander

**Municipality of Residence (Borough):**

**Date of Birth:** (MM/DD/YY)

**Parent/Guardian:**

**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

**Address:**
City: State: ZIP Code:

**Family and Contact Info:**

**Telephone:**
Cell: __ __ __ __ __ __ __ __ __
Home ( ) __ __ __ __ __ __ __ __
Work ( ) __ __ __ __ __ __ __ __

**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: 718-722-2998 or 718-722-2996
  - 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

**Select Only One:**

**Suspected of Delay Primary Referral Reason (EI):**
- □ Adaptive □ Cognitive □ Communication □ Physical
- □ Social/Emotional □ Diagnosis: ____________________________
- Other concerns: ____________________________

**Compatible Reason for Referral:**
- 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
Care Manager: ________________ Phone: ( ) __ __ __ __ __ __

**Child in a Health Home:** □ Yes □ No
Care Management Agency: ____________________________

**Child’s Doctor:**
Doctor’s Phone: ( ) __ __ __ __ __ __

**Birth:**
- **Hospital:**
- **Location:**
- **Birth Weight:** Pounds: __ __ __ __ __ __ __ __ __ __ __ __ Ounces: __ __ __ __ __ __ __ __ __ __ __ __ Grams: __ __ __ __ __ __ __ __ __ __ __ __ Gestational Age: __ __ __ __ __ __ weeks

**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.”

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