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

Name: __________________________
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’s Name: __________________________
Date of Birth: (MM/DD/YY) __ __ / __ __ / __ __

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

Municipality of Residence (Borough): __________________________

Mother’s Name: __________________________
Date of Birth: (MM/DD/YY) __ __ / __ __ / __ __

Father’s Name: __________________________
Date of Birth: (MM/DD/YY) __ __ / __ __ / __ __

Dominant Language*: __________________________

Dominant Language*: __________________________

English proficient***? ☐ YES ☐ NO

Alternate Caregiver Contact Name: __________________________

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

Dominant Language*: __________________________

English proficient***? ☐ YES ☐ NO

Phone: (_______) _______ _______ _______ _______ _______

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

City: __________________________ State: __________________________ Zip Code: __________________________

Address: __________________________

Telephone: __________________________
Cell: (_______) _______ _______ _______ _______ _______
Home: (_______) _______ _______ _______ _______ _______
Work: (_______) _______ _______ _______ _______ _______

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: __________________________
Other concerns: __________________________

At Risk ofDelay 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 Management Agency: __________________________
Care Manager: __________________________ Phone: (_______) _______ _______ _______ _______

Child in a Health Home: ☐ Yes ☐ No
Child’s Doctor: __________________________
Doctor’s Phone: (_______) _______ _______ _______ _______

Birth Hospital: __________________________
Location: __________________________

Birth Weight: Pounds: _______ Ounces: _______ or Grams: _______ Gestational Age: _______ weeks

3. REQUIREDS 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: __________________________

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