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. • 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)* ___/___/___

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 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): | **Primary/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 living in **any** NYC Borough.

Fax to the Citywide Early Intervention Referral Unit: **347-396-8801**

☐ **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

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

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." **EIP 2/2024**

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