



Early Intervention Program Referral Form

FOR OFFICE USE ONLY

Date of Referral

Re-open

Employees of the Administration for Children's Services (ACS) or agencies contracted with ACS must Call the Citywide ACS Referral Hotline: (877)-885-KIDZ(5439) to make a referral to the Early Intervention Program

1. REQUIRED INFORMATION

CHILD'S NAME: (Last, First, Middle)		DATE OF BIRTH: (MM/DD/YY) ___/___/___	
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	CHILD'S ADDRESS: (Street, Apt. No)		CITY: _____
		Zip Code: _____	
RACE (may select more than one if applicable): <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Native American or Alaskan <input type="checkbox"/> Hawaiian or Pacific Islander		ETHNICITY: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic	
MOTHER'S NAME: (Last, First, Middle)		TELEPHONE:	
Caregiver or Alternate Contact Name: (Last, First)		<input type="checkbox"/> Home (____) _____ - _____	
Telephone: (____) _____ - _____		<input type="checkbox"/> Cell (____) _____ - _____	
Relation to Child: <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other, <i>Specify:</i>		<input type="checkbox"/> Work (____) _____ - _____	
REASON FOR REFERRAL (Check only one)		Person Presenting Referral to Early Intervention	
<input type="checkbox"/> 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: Bronx (718) 410-4504 Brooklyn (718) 722-2998 Manhattan (212) 487-7071 Queens (718) 271-6114 Staten Island (718) 420-5360		Name	
		Agency or Facility, if any	
		Address (Street, Apt. No)	
		City, State, Zip	
		Telephone _____ Fax _____ (____) _____ (____) _____	
		Referral Source Type: <input type="checkbox"/> Community Program or EI Agency <input type="checkbox"/> Parent/Family <input type="checkbox"/> Foster Care/Other ACS <input type="checkbox"/> PCP <input type="checkbox"/> Hospital <input type="checkbox"/> Other (<i>Specify</i>):	
<input type="checkbox"/> 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 Child Find Citywide Office: (212) 227-3642			
Comments:			

2. WITH INFORMED PARENTAL CONSENT

MOTHER'S DATE OF BIRTH: (MM/DD/YY) ___/___/___	PRIMARY HOME LANGUAGE:	CHILD KNOWN TO ACS: <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD'S DOCTOR:	DOCTOR'S TELEPHONE: (____) _____ - _____	
BIRTH HOSPITAL:	LOCATION:	
BIRTH WEIGHT: Pounds: ___ Ounces: ___ OR Grams: _____	Gestational: Age: ___ weeks	DIAGNOSIS: if known:

3. REQUIRES PARENTAL SIGNATURE

Consent to Release Information (Only this section requires written parental consent)

I authorize for a copy of the Multidisciplinary Evaluation (MDE) to be sent to the above signed referring professional (ex: Primary Care Provider)

_____ Date _____

Parent Signature

Request for ISC		FOR OFFICE USE ONLY	
Requested ISC	SC ID No.	Assigned SC	ISC Request <input type="checkbox"/> Approved <input type="checkbox"/> Not Approved
Agency	ID No.	Agency	ID No.
Tel. (____) _____ - _____	Fax (____) _____ - _____	Tel. (____) _____ - _____	Fax (____) _____ - _____
Reason for ISC Request		Data Entry	Date ___/___/___

Questions? Dial 311 and ask for Early Intervention EIP 11/10

Instructions for Completing the Early Intervention Program Referral Form

(Please do not fax with the referral form)

NOTE TO REFERRAL SOURCE:

ACS Referral Hotline: Child with a suspected of known delay OR Child is typically developing but may be “at risk” for atypical development AND is involved in the ACS Foster Care, Protective Services or Preventative services. Early Intervention Specialists at the ACS Hotline will discuss appropriate Next steps in the Early Intervention process. **All ACS referrals must be called in using this designated hotline number.** Fax referrals are discouraged for ACS referrals.

Write legibly or type all referral information. The referral form is divided into three (3) sections.

Section 1 - Contains information fields that **must** be included when making a referral to the NYC Early Intervention Program (EIP). Section 1 does not require parental consent to submit this information. **This section should be filled out completely for the referral to be accepted.**

Note: Family has the right to refuse to have their child referred to EIP.

Section 2 - Contains information that should be transmitted only with informed parental consent. Consent can be verbal or taken from another consent form used by the referring agency.

Section 3 - Contains information that requires a parent’s written signature on this Referral Form.

Although Sections 2 and 3 require parental consent, the information contained in these sections is important for appropriate routing of the referral and assignment of Initial Service Coordinator (ISC). Therefore, it is recommended that all sections be completed if possible.

Information on this form must be typed or printed legibly (other than parent signature in Section 3).

Section 1

1. Write the child’s full name, last name first. Write the child’s date of birth in two (2) digit month, day, and year (e.g., 03/25/09).
2. Check the box indicating the child’s gender and write the full address where the child resides, including the city (or borough) and the zip code.
3. **Race and Ethnicity.** Check the appropriate box for each section. *More than one racial designation for a child can be selected.*
4. Write the name of the child’s biological or adoptive mother, last name first. On the right side, write the telephone numbers where the mother can be contacted.
5. Write the name of an alternate caregiver (such as the foster parent) or contact person and that person’s telephone number. Check the appropriate box to indicate the relationship to the child and specify what that is if “other” is checked.
6. **Reason for Referral.** Check Early Intervention, Developmental Monitoring or ACS Hotline. If the child is being referred because there is a particular concern, write that information in the *Comments* box (See Appendix A). **All ACS referrals must be called in using the designated hotline number. Fax referrals are discouraged for ACS referrals.**
7. **Person Presenting Referral to Early Intervention.** Write the name, agency or facility (if any), address, telephone and fax numbers of the person referring the child to NYCEIP and completing this form. Check the appropriate box for *Referral Source Type* reflecting the person who is actually making the referral. For example, check the box for Community Program or EI Agency if the person making the referral represents an EI Provider Agency or a community agency (e.g., ECDC). Additional information can be added in the *Comments* box.

Section 2

8. Write the mother’s date of birth in two (2) digit month, day and year (e.g., 11/10/82).
9. Write the primary language spoken at home. This information will assist in determining whether a bilingual ISC needs to be assigned.
10. Check the appropriate box to indicate whether the family is known to ACS.
11. Write the name of child’s primary health care provider and his/her telephone number.
12. Write the name of the hospital in which the child was born and the location, e.g., address, borough or city and state/country.
13. Write the child’s birth weight in pounds and ounces or grams. Include the gestational age in weeks, if known.
14. If the child has a known diagnosis, write that here (e.g., autism, Down syndrome, cerebral palsy, etc.). General concerns can be written in the *Comments* box.

Section 3

15. Indicate if a copy of the Multidisciplinary Evaluation (MDE) should be sent to the referring professional if the parent consents to the release of this information. This section requires written parental consent on this form and no information should be provided without the parent’s signature.

Request for ISC

16. If the person/agency making the referral is requesting a particular initial service coordinator (ISC), write the name of the Service Coordinator (SC), the SC’s ID number, the name and ID number of the service coordination agency, and the telephone and fax numbers for the agency. Include the reason for requesting initial service coordination. According to NYS law, a specific ISC or ISC agency can be requested when there is “an established relationship with the child or family.” However, the EI Regional Office (RO) determines the assignment of ISC and documents this in the bottom right box on the form.

Note: A specific ISC or ISC agency can be requested when there is an established relationship with the child or family, but assignment is at the discretion of the EI RO.

NOTE: If there are questions about completing the form or making the referral, call the EI RO in the borough where the child resides or call 311 and ask for “Early Intervention.”

Appendix A- Reason for Referral Clarification

Section 1 contains the **REASON FOR REFERRAL** block. The individual referring the child must indicate whether the child is being referred to EIP in the child’s borough of residence, **Child Find Developmental Monitoring (DM) or the ACS Referral Hotline**. The following indicators should assist with deciding 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 EIP Regional Office (RO) in the child’s borough of residence for a Multidisciplinary Evaluation (MDE). Check this box for a child with a developmental delay(s) and/or a diagnosed physical or mental condition with a high probability of a future developmental delay. The child should meet one or more of the following criteria:

- The child has a condition with a known likelihood of leading to a developmental delay such as Down Syndrome, a birth weight of less than 1,000 grams (2.2 pounds), failure of two (2) hearing screenings or has a 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 indicate that he or she is not developing similarly to same age peers; or
- Parent or caregiver 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, or child missed or a failed newborn hearing screening or re-screening (not re-screened within seventy-five (75) days).

This referral is sent to the citywide Child Find - DM Office. Check this box for a child who missed or failed his/her newborn hearing screening and did not return for follow-up within seventy-five (75) days. Also, check this box for a child who meets one or more of the risk criteria listed below:

Neonatal Risk Criteria	Post-Neonatal Risk Criteria	Other Risk Criteria
<ul style="list-style-type: none"> • Birth weight 1,000 - 1,500 grams • Gestational age less than 33 weeks • NICU stay of ten (10) days or more • CNS insult/abnormality • Asphyxia (5 min APGAR less than 4) • Growth deficiency/nutrition problems (e.g., SGA) • Presence of Inborn Metabolic Disorder • Maternal prenatal alcohol abuse • Congenital malformations • Hyper- or hypotonicity • Hyperbilirubinemia (above 15 mg/d) • Hypoglycemia (serum glucose less than 20 mg) • Maternal prenatal abuse of illicit substances • Prenatal exposure to therapeutic drugs with known risk • Venous lead level more than 19 mcg/dl • HIV infection • Maternal PKU 	<ul style="list-style-type: none"> • Parental developmental disability or mental illness • Suspected/family history of hearing impairment • Suspected/family history of vision impairment • Other risk criteria identified by referral source (describe) • Parental concern re: development • Questionable score on Developmental/sensory screen • Illness/trauma with CNS Implications and ICU more than ten (10) days • Serous Otitis Media within three (3) months • Growth deficiency/nutritional problems, F.T.T., iron deficiency 	<ul style="list-style-type: none"> • No prenatal care • Homelessness • Questionable score on Developmental/Sensory screen • History of child abuse or neglect* • No well child care by six (6) months • Concern re: parenting due to poor bonding, impairment in psychological/ interpersonal functioning • Significant immunization delay • Parental drug or alcohol abuse • Perinatally/congenitally transmitted Infection (e.g., HIV, hepatitis B, syphilis) • Parental developmental disability or mental illness • Other risk criteria identified by referral source (describe) <p>* Referrals of typically developing children in ACS Foster Care who have not been screened should be sent to DM</p>