Early Intervention Program Referral Form

FOR OFFICE USE ONLY
Date of Referral
☐ *Re-open*

1. REQUIRED INFORMATION

CHILD'S NAME *(Last, First, Middle)*

DATE OF BIRTH *(MM/DD/YY)* __ __/__ __/__ __

SEX ☐ Male ☐ Female

CHILD'S ADDRESS: *(Street, Apt. No)*

CITY

Zip Code __ __ __ __ __

RACE (Required – may select more than one if applicable)
☐ White ☐ Asian ☐ Black ☐ Native American or Alaskan ☐ Hawaiian or Pacific Islander

ETHNICITY (Required)
☐ Hispanic ☐ Not Hispanic

MOTHER'S NAME *(Last, First, Middle)*

Caregiver or Alternate Contact Name *(Last, First)*

_____

Telephone (__ __ __) __ __ __- __ __ __ __

Relation to Child ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Other, *Specify:*

TELEPHONE
☐ Home (__ __ __) __ __ __- __ __ __ __
☐ Cell (__ __ __) __ __ __- __ __ __ __
☐ Work (__ __ __) __ __ __- __ __ __ __

REASON FOR REFERRAL *(Check 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:

Bronx	(718) 410-4504
Brooklyn	(718) 722-2998
Manhattan	(212) 487-7071
Queens	(718) 271-6114
Staten Island	(718) 420-5360

☐ **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 Office:
Citywide (212) 227-3642

Person Presenting Referral to Early Intervention

Name

Agency or Facility, if any

Address *(Street, Apt. No)*

City, State, Zip

Telephone (__ __ __) __ __ __- __ __ __ __

Fax (__ __ __) __ __ __- __ __ __ __

Referral Source Type: ☐ Community Program or EI Agency ☐ Parent/Family ☐ Foster Care/Other ACS ☐ PCP ☐ Hospital ☐ Other *(Specify):*

Comments

2. WITH INFORMED PARENTAL CONSENT

MOTHER'S DATE OF BIRTH *(MM/DD/YY)* __ __/__ __/__ __

PRIMARY HOME LANGUAGE:

CHILD KNOWN TO ACS ☐ Yes ☐ 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

HEALTH INSURANCE COVERAGE INFORMATION

I am insured by _____ under policy number _____. I consent to the inclusion of this insurance information in this referral to the New York Department of Health and Mental Hygiene for Early Intervention services for my child. I understand that no services will be billed to my insurance plan until services are authorized for my child.

Only this section requires written parental consent.

_____ Parent Signature

_____ Date

Request for ISC

Requested ISC SC ID No.

Agency ID No.

Tel. (__ __ __) __ __ __- __ __ __ __ Fax (__ __ __) __ __ __- __ __ __ __

Reason for ISC Request

FOR OFFICE USE ONLY **ISC Request** ☐ **Approved** ☐ **Not Approved**

Assigned SC SC ID No.

Agency ID No.

Tel. (__ __ __) __ __ __- __ __ __ __ Fax (__ __ __) __ __ __- __ __ __ __

Data Entry Date __ __/__ __/__ __

Questions? Dial 311 and ask for Early Intervention **EIP 04/09**

Instructions for Completing the Early Intervention Program Referral Form

(Please do not fax this page with the referral form)

Write legibly or type all referral information. The referral form is divided into three 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.
Note that a family has the right to refuse to have their child referred to EIP.

Section 1 contains the **REASON FOR REFERRAL** block. The individual referring the child is asked to check the box indicating whether the child is being referred to EIP in the child's borough of residence **or** to Child Find **Developmental Monitoring (DM)**. 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 in the child's borough of residence for a multidisciplinary evaluation. 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 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 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 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
Birth weight 1,000 - 1,500 grams Gestational age less than 33 weeks NICU stay of 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	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 10 days Serous Otitis Media within 3 months Growth deficiency/nutritional problems, F.T.T., iron deficiency	No prenatal care Homelessness Questionable score on Developmental/Sensory screen History of child abuse or neglect* No well child care by 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) * Referrals of typically developing children in ACS Foster Care who have not been screened should be sent to DM

Section 2 contains information that should be transmitted only with informed parental consent. This consent can be verbal or taken from another consent form used by the referring agency. This information is important and every effort should be made to obtain consent and transmit this information to the EI Regional Office or the Child Find – Developmental Monitoring Unit.

Section 3 asks for the family's health coverage information and requires a parent's written signature on this form. If asked, inform the family that if they have health insurance, New York City is required by law to ask their insurance company for payment for Early Intervention Services. The family is not responsible for out-of-pocket costs.

Note: A specific initial service coordinator (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 Office.