NYC Health 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 ☐ Male ☐ Female

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

CITY:

Zip Code: __ __ __ __ __

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

ETHNICITY: ☐ 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) 436-0902
Queens	(718) 291-1981
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 DM Citywide Office: (347) 396-6987

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

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)

_____ _____
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 1/16**