NYC Health — EARLY INTERVENTION PROGRAM REFERRAL FORM

FAX THIS FORM TO THE APPROPRIATE OFFICE:

For a child with a suspected or known disability or delay—to the Regional Office of the child's residence
Bronx (718) 410-4504   Brooklyn (718) 722-2998   Manhattan (212) 487-7071
Queens (718) 271-6114   Staten Island (718) 351-2585

For an "at-risk" child—to the Child Find Unit
Citywide: (212) 227-3642

FOR OFFICE USE ONLY *(Date of Referral)*

☐ Re-Open

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

CHILD'S DATE OF BIRTH *(MM/DD/YY)* __ __ / __ __ / __ __   **SEX** ☐ Male ☐ Female   **RACE** ☐ White ☐ Asian/Pacific Islander ☐ Other, *Specify:* ☐ Black ☐ Alaskan/Native American   **ETHNICITY** ☐ Hispanic ☐ Not Hispanic

CHILD'S ADDRESS *(Street, Apt No.)*   **BOROUGH**   **ZIP CODE** __ __ __ __ __

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

MOTHER'S DATE OF BIRTH *(MM/DD/YY)* __ __ / __ __ / __ __   **LANGUAGES USED AT HOME**   **TELEPHONE**
☐ Home (__ __ __) __ __ __ – __ __ __ __
☐ Cell (__ __ __) __ __ __ – __ __ __ __
☐ Work (__ __ __) __ __ __ – __ __ __ __

CAREGIVER'S NAME *(Last)* if different from above   *(First)*

RELATION ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Other, *Specify:*   **CHILD KNOWN TO ACS** ☐ Yes ☐ No

CHILD'S DOCTOR   **DOCTOR'S TELEPHONE** (__ __ __) __ __ __ – __ __ __ __

BIRTH HOSPITAL   **LOCATION**

BIRTH WEIGHT ☐ Pounds: ___ ___ Ounces: ___ ___ **OR** ☐ Grams: ___ ___ ___ ___   **DIAGNOSIS** *if known:*

REASON FOR REFERRAL *(Check only ONE)*

☐ **This child is suspected or known to have a developmental delay or disability.**

   OR

☐ **This child is developing typically at this time but may be at risk for atypical development.**
(Examples of this are: no prenatal care; maternal prenatal alcohol and/or substance abuse; NICU stay of 10 days or more; Elevated venous lead levels; Growth deficiency/ nutritional problems; Homelessness; Concern regarding parent-child interaction; Parental developmental disability or mental illness).

Person Making Referral

Address *(Street, Apt No.)*

City, State, Zip

Tel. (__ __ __) __ __ __ – __ __ __ __   **Fax** (__ __ __) __ __ __ – __ __ __ __

Referring Agency/Facility

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

COMMENTS

Request for ISC		FOR OFFICE USE ONLY ISC Request ■ Approved ■ Not Approved	
Requested SC	**SC ID No.**	**Assigned SC**	**SC ID No.**
Agency	**ID No.**	**Agency**	**ID No.**
Tel. ( ) – **Fax** ( ) –		**Tel.** ( ) – **Fax** ( ) –	
Reason for Request		**Data Entry**	**Date** ___ / ___ / ___

Questions? Dial 311 and ask for Early Intervention   EIP-16 9/06