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*

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

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

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: __ __ __ __

GESTATIONAL AGE weeks

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

Requested SC | **SC ID No.**

Agency | **ID No.**

Tel. ( ) – **Fax** ( ) –

Reason for Request

FOR OFFICE USE ONLY — ISC Request ■ Approved ■ Not Approved

Assigned SC | **SC ID No.**

Agency | **ID No.**

Tel. ( ) – **Fax** ( ) –

Data Entry | **Date** ____ / ____ / ____

** This information does not have to be obtained if the parent objects.*