☐ **New Referral**
☐ **Re-Referral Case Reference #**
_____

Time:

NASSAU COUNTY DEPARTMENT OF HEALTH EARLY INTERVENTION PROGRAM
INTAKE/REFERRAL
Fax (516) 227-8662

Nassau County Responsible Staff_____ Date Assigned_____

Referral Source Type: ☐ **Parent/Family**_____ ☐ **Community Program or EI Agency** ☐ **Foster Care**
☐ **Primary Healthcare Provider** ☐ **Hospital** ☐ **WIC** ☐ **Other *(Specify)*: _____**

If Parent Referral Identify Original Contact_____

Referral Source Name: _____ **Agency:** _____

Address: _____**Phone Number:** (____)_____

Agency holds parental written consent: ☐ **YES** ☐ **NO**

Child's Last Name: _____**First Name:** _____ M.I._____

AKA as Last Name: _____**AKA as First Name:**_____

Child's DOB _____/_____/_____**Gender:** ☐ **Female** ☐ **Male** **Weeks Gestation** _____**Birth Weight** _____

Multiple Birth ☐ Yes ☐ No **Multiple Birth Order**_____ **County of Birth** _____ **Hospital** _____**County of Residence 29 (Nassau)**

RESPONSIBLE ADULTS (First and Last name)

Relationship

_____ ☐ **Mother** ☐ **Other** _____ **DOB**_____/_____/_____ **Legal Guardian Yes / No**

_____ ☐ **Father** ☐ **Other** _____ **DOB**_____/_____/_____ **Legal Guardian Yes / No**

_____ ☐ **Foster Mother** ☐ **Foster Father** **Legal Guardian Yes / No**

Address: _____ **Home Phone**: (____)_____ ☐ **Primary**

Apt. #:_____ **Cell Phone:** (_____)_____ ☐ **Primary**

City/Town:_____ **Work Phone:** (_____)_____ ☐ **Primary**

State: NY **Zip Code:** _____ **Language Spoken at Home:** ☐ **English** ☐ **Spanish** ☐ **Other** _____

Receive e-mail: ☐ **No** ☐ **Yes** **e-mail Address:**

School District:_____

Medicaid? ☐ No ☐ Yes CIN # _____ Child's SS#:_____

Race: ☐ White ☐ Asian ☐ Black ☐ Native American or Alaskan ☐ Hawaiian or Pacific Islander

Ethnicity (Required): ☐ Hispanic ☐ Not Hispanic

Reason for Referral

☐ **EARLY INTERVENTION:** Child with a suspected or known developmental delay or disability.
☐ **AT-RISK:** Child may be at-risk for atypical development or child missed / failed newborn hearing screening.

Describe: _____

_____

Medical Diagnosis: _____

Parents have been provided with the following information at intake:

	An Initial service coordinator (ISC) will be assigned who will promptly arrange a contact with the parent in a time, place and manner reasonably convenient for the parent and consistent with applicable timeliness requirements.
	The ISC will review all options for evaluation and screening with the parent from the list of approved evaluators.
	Neither the county nor the ISC may request that a parent delay a referral or evaluation.

ISC will discuss Child Find Options when indicated:

ISC Initials:	ISC will discuss Child Find Options for developmental tracking when indicated.

Intake Date _____/_____/_____ **Taken By**_____

45 Day IFSP Due _____/_____/_____ Referral Entered into KIDS/NYEIS _____/_____/_____