NEW YORK STATE DEPARTMENT OF HEALTH
Early Intervention Program

Program Referral

CHILD'S COUNTY OF RESIDENCE: Niagara **CHILD'S DATE OF REFFERAL:** ____/____/____

Niagara County Referral Fax Number: 716-304-6610

☐ **Section 1:** REQUIRED INFORMATION (By checking this box, the Municipality indicates they have received confirmation from the referral source that the parent/legal guardian was consulted, and did not object to the referral)

Child Information

CHILD'S NAME:

Last Name _____ First Name _____ Middle Name _____

DATE OF BIRTH: (MM/DD/YYYY) ____/____/____

DOMINANT LANGUAGE or MODE OF COMMUNICATION:

Child _____ Parent/Legal Guardian _____

SEX: ☐ Male ☐ Female

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

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

RACE: (select more than one if appropriate)
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

REASON FOR REFERRAL: (Please only check ONE)

☐ 1. **SUSPECTED** This child is being referred because he/she is suspected of having a developmental delay or disability.

☐ 2. **CONFIRMED** This child is being referred because he/she has a confirmed disability (diagnosed physical or mental condition that has a high probability of resulting in developmental delay).

☐ 3. **AT RISK** This child is **NOT** suspected of having a disability at this time but is being referred because he/she is **AT RISK** of having a disability (e.g., risk criteria identified in regulation, CAPTA referrals, etc.).

☐ 4. **AT RISK** Infant did not pass newborn hearing screening and did not receive necessary follow-up.

Referral Source Information

REFERRAL SOURCE INFORMATION:

Last Name _____ First Name _____

Agency/Facility Name: _____

Address: _____

Telephone: (____) ____ - ____ Ext. ____

Fax: (____) ____ - ____

Email: _____

REFERRAL SOURCE TYPE: (Please only check ONE)

☐ Parent/Legal Guardian
☐ Other Family Member (Specify)_____
☐ Child Primary Healthcare Provider
☐ Hospital or Clinic
☐ Community Program/ EIP Provider
☐ Other (Specify)_____

Parent/Legal Guardian Contact Information

PARENT/LEGAL GUARDIAN NAME:

Last Name _____ First Name _____

Home: (____) ____ - ____ Cell: (____) ____ - ____

Work: (____) ____ - ____

Address:

Street, Apt. No. _____

City _____ Zip Code _____

PARENT/LEGAL GUARDIAN NAME:

Last Name _____ First Name _____

Home: (____) ____ - ____ Cell: (____) ____ - ____

Work: (____) ____ - ____

Address:

Street, Apt. No. _____

City _____ Zip Code _____

CAREGIVER/ALTERNATE CONTACT NAME:

Last Name _____ First Name _____

Telephone Number: (____) ____ - ____

RELATIONSHIP TO CHILD:

☐ Grandparent Other: _____
☐ Foster Parent

CHILD'S NAME: _____ **DATE OF BIRTH:** ____/____/____
Last Name First Name MM DD YYYY

Section 2: THE FOLLOWING INFORMATION REQUIRES INFORMED, WRITTEN PARENTAL CONSENT TO SHARE:

Informed Written Parent/Legal Guardian Consent Required

☐ **Referral Source confirms they have informed, written parental consent to include the following information and any attached documents.**

Referral Source Signature: _____

Referral Reason Additional Information:

Provide additional information about developmental concerns. Include any testing that has been completed and child's functioning in one or more developmental areas that may constitute a developmental delay that may establish the child's eligibility for the EIP.

Please check all functional areas that the child is demonstrating delays (include relevant comments or note if documents are attached):

☐ **Adaptive:** _____

☐ **Cognitive:** _____

☐ **Communication:** _____

☐ **Physical (gross and fine motor skills and includes vision, hearing, oral motor feeding and swallowing**

_____

☐ **Social-Emotional:** _____

☐ **Documentation is attached:** _____

☐ **Diagnosed Condition(s) (include diagnosis /International Classification of Diseases (ICD-10) codes:**

_____

Additional Referral Details: _____

Parent/Legal Guardian's Signature: _____ **Date:** ____/____/____

Please note: If the fillable Referral Form includes a parent/legal guardian's electronic signature for consent to attach child records/reports, **that signature must also include an electronic signature validation marker (available through applications like Adobe Acrobat, DocuSign etc.) that includes the signature date and time on the form.** If that safeguard is not available and a parent/legal guardian signature is needed for Section 2, the Referral Form must be **printed** to allow the parent/legal guardian to sign for consent on the paper copy.

☐ With parent's informed written consent, please ATTACH RECORDS or REPORTS that would assist in determining eligibility for the Early Intervention Program.

Niagara County EIP Staff Use:

ISC Assigned: _____ Electronic Record #_____

45th Day: ____/____/____ LHU #_____

Pediatrician (if not referral source): _____

_____

Notes (Reason for Referral, Other Info.): _____

_____

_____

EIP Staff:

*Please see instructions when completing this form. Form can be mailed, faxed, or delivered to the Early Intervention Program in the child's county/municipality of residence.