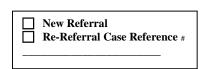
New Referral Re-Referral Case Reference #	NASSAU COUNTY DEPARTMENT OF HEALTH EARLY INTERVENTION PROGRAM INTAKE/REFERRAL Fax (516) 227-8662								
Nassau County Responsible Staff Date Assigned									
	arent/Family Community Program or EI Agency Foster Care wider Hospital WIC Other (<i>Specify</i>):								
If Parent Referral Identify Or	iginal Contact								
Referral Source Name:	Referral Source Name:								
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 GestationBirth Weight								
Multiple Birth Yes No I	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									
City/Town:	Work Phone: () Primary								
City/Town: State: <u>NY</u> Zip Code:									
State: <u>NY</u> Zip Code:									
State: <u>NY</u> Zip Code: School District	Language Spoken at Home: English Spanish Other								
State: <u>NY</u> Zip Code: School District Pediatrician:	Language Spoken at Home: English Spanish Other								
State: <u>NY</u> Zip Code: School District Pediatrician: Medicaid? No Y	Language Spoken at Home: English Spanish Other								
State: <u>NY</u> Zip Code: School District	Language Spoken at Home: English Spanish Other								
State: <u>NY</u> Zip Code: School District Pediatrician: Medicaid? No Y	Language Spoken at Home: English Spanish Other								
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State: NY Zip Code:	Language Spoken at Home: English Spanish Other								

Complete all bolded information and fax to (516) 227-8662.

If you need assistance completing this form please call (516) 227-8647.

1. Referral Type and EIOD Assignment Section

- a. Indicate if this is a new referral or a re-referral. If known, fill in the NYEIS Case Reference number.
- b. Leave Nassau County Responsible Staff and Date Assigned blank.



Nassau County Responsible Staff_

Date Assigned

2. Referral Source Section

- a. check off referral source type
- b. if the parent is referral source indicate how the parent learned of our program such as pediatrician, family friend, day care etc.
- c. enter your name and the name of your agency
- d. enter your agency's address and telephone number
- e. check off whether or not your agency holds the parental written consent

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					

3. Child Information

- a. enter the child's complete last name (the name on the child's birth certificate), first name, and middle initial
- b. enter the information in the AKA line if the child is known by another last name or another first name
- c. fill in the child's date of birth, check off the correct gender, fill in the weeks gestation and the birth weight
- d. indicate if this is a multiple birth, how many children in the multiple birth, fill in the County of birth and the hospital if known, note a child born at LIJ Schneider's was born in Queens and receives a New York City birth certificate

Child's Last Name:			First N	ame:	M.I		
AKA as Last Name:	AKA as Last Name:AKA as First Name:						
Child's DOB	/ /	Gender:	Female Male	Weeks Gestation _	Birth Weight		
Multiple Birth Yes] No Multiple Bir	th Order	County of Birth	Hospital	_County of Residence 29 (Nassau)		

4. Responsible Adults Section

- a. fill in the mother's first and last name and date of birth, indicate if she is a Legal Guardian
- b. fill in the father's first and last name and date of birth, indicate if he is a Legal Guardian
- c. if applicable, fill in the foster parent information and circle yes or no to indicate Legal Guardian information

RESPONSIBLE ADULTS (First and Last name)						
	Relation	ship				
	Mother	Other	_DOB	_/	_/	_ Legal Guardian Yes / No
	Father	Other	_ DOB	_/	_/	_ Legal Guardian Yes / No
	Foster M	lother 🗌 Foster Father	Legal Gua	rdian Y	es / N	0

5. Address, Language, and Contact Information

a. enter the child's complete address information

b. enter the telephone contact information for the child, check box for the primary contact number, check off the language spoken at home, and if it is Other, indicate the language spoken on line provided

Address:	Home Phone: ()	Primary
Apt. #:	Cell Phone: ()	Primary
City/Town:	Work Phone: ()	Primary
State: <u>NY</u> Zip Code:	Language Spoken at Home: English Spanish	Other

6. Additional Case Information

a. completed by the Nassau County EIOD

School District	
Pediatrician:	Phone: ()
Medicaid? No Yes CIN #	Child's SS#:
Race: White Asian Black Native American or Alaskan	Hawaiian or Pacific Islander
Ethnicity (Required): Hispanic Not Hispanic	

7. Reason for Referral

- a. indicated this is an early intervention or and at risk referral
- b. describe the reason for referral
 - c. indicate medical diagnosis, if any

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: ____

EI 50

Medical Diagnosis:

8. Assurances

a. Initial next to each section attesting this information was conveyed to the Parent/Guardian

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.

9. Child Find Option

a. initial service coordinator will complete this section

ISC will discuss Child Find Options when indicated:

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

10. County Intake Information

a. completed by Nassau County

	Intake Date	 /	/	 Taken By
49.B 10/19/2015	45 Day IFSP Due	 /	/	 Referral Entered in