

- New Referral
- Re-Referral Case Reference # _____
- Transfer _____

Time: _____

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



Nassau County Responsible Staff _____ Date Assigned _____

Axiom: No Yes Sibling Currently Enrolled: Yes No Previous EIOD: _____

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. _____

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

Multiple Birth Yes No County of Birth _____

RESPONSIBLE ADULTS (First and Last name)

	Relationship		
<input type="checkbox"/> Mother	<input type="checkbox"/> Other	DOB ____/____/____	Legal Guardian Yes / No
<input type="checkbox"/> Father	<input type="checkbox"/> Other	DOB ____/____/____	Legal Guardian Yes / No
<input type="checkbox"/> Foster Mother	<input type="checkbox"/> Foster Father		Legal Guardian Yes / No

Address: _____ Mom's Phone: (____) _____ Primary

Apt. #: _____ Dad's Phone: (____) _____ Primary

City/Town: _____ Other Phone: (____) _____ Primary

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

Receive e-mail: No Yes e-mail Address: _____

Medicaid? No Yes CIN # _____ Ethnicity (Required): Hispanic Not Hispanic

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

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 By: _____