Help Me Grow - Long Island Referral Form
(for Families with Children Prenatal - Age 5 in Nassau and Suffolk Counties)

Has the family agreed to this referral? ☐ Yes ☐ No **Parent Signature** _____

Referring Provider Information (Person Who Should Receive Follow-Up)			
Referral Date	**Referral Site Name**	**Referring Provider Name**	**Title**
Address		**Unit**	**City**	**Zip Code**
Best Phone Number For Follow-Up	**Fax Number***	**Email**

Has a developmental screen ever been given? ☐ Yes ☐ No

If yes: Screen and results/score:

Did you refer child/family to (check all that apply)?

☐ Early Intervention (Date Submitted: _____) ☐ Mental Health Services (Date Submitted: _____)

☐ Pre-school Special education (Date Submitted: _____) ☐ Other: _____ (Date Submitted: _

Child's Information (AGE 5 OR UNDER) - put "n/a" if prenatal			
Child's Last Name	**Child's First Name**	**DOB (5 OR UNDER)**	**Gender** ☐ F ☐ M
Address	**Unit**	**City**	**Zip Code**

Caregiver's Information			
Parent/Caregiver Last Name	**Parent/Caregiver First Name**	**Relationship to Child**	**Language(s) Spoken**
Best Phone (check one) ☐ Home ☐ Work ☐ Cell		**Other Phone (check one)** ☐ Home ☐ Work ☐ Cell	
Email:			
Best time to contact ☐ Morning (9AM-12PM) ☐ Afternoon (12PM-5PM) ☐ Evening (5PM-7PM)			

Reason for Referral (Check Off All that Apply)		
☐ Basic needs	☐ Developmental concern	☐ Legal assistance
☐ Behavior/social interactions	☐ Developmental screening	☐ Mental health (☐ parent ☐ child)
☐ Cognitive/learning difficulty	☐ Fine motor/Gross motor	☐ Service/referral Navigation
☐ Child care/early child education	☐ General HMG information	☐ Other _____
☐ Communication	☐ Parent support	

Comments:

**HMG-LI will confirm when the fax was received; please contact us if you have not heard within 2 business days. HMG-LI will contact you once referrals were made and continually until the case is considered closed. Please call or email for updates prior to then as needed.*

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