☐ **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_____

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** _____

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

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 _____/_____/_____

Instructions for completing EI 5049.B 10/2015 Intake/Referral form

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.

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

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 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)

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)

Relationship

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

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

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

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: NY **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: _____

_____

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_____

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