

# Help Me Grow – Long Island Universal Provider Referral Form



For Families with Children Aged Prenatal-5 Living in Nassau or Suffolk Counties

\*Has the family agreed to this referral and to sharing information?  Yes  No

\*Parent Signature/Verbal Consent \_\_\_\_\_

<b>Referring Provider Information (Person Who Should Be Receiving Follow-Up Correspondence)</b>			
<b>Referral Date</b>	<b>Referral Site Name:</b>	<b>Referring Provider Name:</b>	<b>Title:</b>
<b>Address:</b>	<b>Unit:</b>	<b>City:</b>	<b>Zip Code:</b>
<b>Best Phone # for Follow-up:</b>	<b>Fax Number*:</b>	<b>Email:</b>	
<b>Indicate if the family has completed any of the following screens:</b>			
<b>Developmental screen:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Screen & Score:			
<b>Social emotional screen:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Screen & Score:			
<b>Autism screen:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Screen & Score:			
<b>Maternal depression screen:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Screen & Score:			
<b>Did you already submit a referral to (Check all that apply):</b>			
<input type="checkbox"/> Early Intervention (Date Submitted: _____)		<input type="checkbox"/> Mental Health Services (Date Submitted: _____)	
<input type="checkbox"/> Pre-school Special education (Date Submitted: _____)		<input type="checkbox"/> Other: _____ (Date Submitted: _____)	
<b>Child's Information (Aged 0-5)- put n/a if prenatal</b>			
<b>Child's Last Name</b>	<b>Child's First Name</b>	<b>DOB (5 or under)</b>	<b>Gender</b> <input type="checkbox"/> F <input type="checkbox"/> M
<b>Address</b>	<b>Unit:</b>	<b>City:</b>	<b>Zip Code:</b>

<b>Caregiver's Information</b>			
<b>Caregiver Last Name</b>	<b>Caregiver First Name</b>	<b>Relationship to Child</b>	<b>Language(s) Spoken</b>
<b>Best Phone (check 1)</b> <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		<b>Other Phone (Check 1)</b> <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	
<b>Email:</b>			
<b>Best time to contact</b> <input type="checkbox"/> Morning (9AM-12PM) <input type="checkbox"/> Afternoon (12PM-5PM) <input type="checkbox"/> Evening (5PM-7PM)			
<b>Reason for Referral (Check Off All that Apply)</b>			
<input type="checkbox"/> Basic needs	<input type="checkbox"/> Developmental concern	<input type="checkbox"/> Mental health ( <input type="checkbox"/> parent <input type="checkbox"/> child)	
<input type="checkbox"/> Behavior/social interactions	<input type="checkbox"/> Developmental screening	<input type="checkbox"/> Service/referral Navigation	
<input type="checkbox"/> Cognitive/learning difficulty	<input type="checkbox"/> Fine motor/Gross motor	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Child care/early child education	<input type="checkbox"/> General HMG information		
<input type="checkbox"/> Communication	<input type="checkbox"/> Parent support		

<b>Comments:</b>
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\*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.