HEALTH DEPARTMENT
Children's Services Unit

DIRECTOR OF PUBLIC HEALTH- Linda Beers, MPH
CHILDREN'S SERVICES COORDINATOR-Lucianna Celotti, BA

EARLY INTERVENTION REFERRAL FORM

CHILD'S INFORMATION:

Name: ____ DOB: ______________ Sex: ________
Last First MI

Parent/Guardian: ____

Phone: ____________________ Alternate Phone(s)____________________ Ethnicity/Race__________________

Address: ____

County of Residence______________________ Foster Child: ☐ Yes (County) ________________ ☐ No

Alternate Contact: ____ Phone: ____________________________

AT RISK CRITERIA:

Referrals of children at-risk of having a disability shall be made based on the following medical/biological risk factors:

☐ Birth weight less than 1501 grams
☐ Maternal PKU
☐ Gestational age <33 weeks
☐ CNS Insult/abnormality
☐ Asphyxia (5 min. Apgar <4)
☐ Congenital malformations
☐ Hyper or hypotonicity
☐ Hyperbilirubinemia above 20 mg/dl)
☐ Hypoglycemia (serum glucose less than 20 mg/dl)
☐ Growth deficiency/nutritional problems at birth (eg, SGA, IUGR)
☐ Growth deficiency/nutritional problems in early childhood (eg, FTT)
☐ Presence of Inborn Metabolic Disorder
☐ Prenatally/congenitally transmitted infection (e.g., HIV, hep B, syphilis)
☐ NICU stay of 10 days or more
☐ Prenatal exposure to therapeutic drugs with known risk
☐ Maternal prenatal drug or alcohol abuse
☐ No well child care by 6 months
☐ Parental concern re:development
☐ Questionable score on developmental screen
☐ Illness/trauma with CNS implications and ICU >10 days
☐ Venous lead level >9 mcg/dl
☐ Serous Otitis Media >3 months
☐ HIV Infection
☐ No prenatal care
☐ Parental developmental disability mental illness
☐ Significant immunization delay
☐ **Genetic Syndrome**
☐ Failed initial hearing screening
☐ Suspected vision/hear impairment
☐ Other risk criteria as identified by the primary referral source:

CONFIRMED OR SUSPECTED DELAY OR DISABILITY:

Functional area(s) of Suspected Delay:
☐ Adaptive
☐ Cognitive
☐ Communication
☐ Social/Emotional
☐ Physical

Referrals may also be based on a diagnosed physical and/or mental condition with a high probability of developmental delay contained in New York State Department of Health's list at

www.health.state.ny.us/community/infants_children/early_intervention/index/htm

then click on Memorandum Guidance and Clinical Practice Guidelines [in the box to the left]

then click on Memorandum 2005-2 [Section V contains the list]

☐ Other reason for referral: ________________________________
____

Comments/Additional Information: ____
____

Referred by:______________________________ Title:________________________ Date of Referral ______________

Address:____ Telephone:________________________

For Office Use Only:
Date Referral Received: _____/______/_____ by EIO(D)

Child Find assigned: ______________________ Initial Service Coordinator Assigned: ______________________

Date: _____/_____/_____ Date: _____/_____/_____

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EARLY INTERVENTION REFERRAL FORM FOLLOW-UP CONTACTS

Follow up Contacts:

Date: _________ ____
Time: _________ ____
____
____
____

Date: _________ ____
Time: _________ ____
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____
____

Date: _________ ____
Time: _________ ____
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____

Date: _________ ____
Time: _________ ____
____

Phone: (518) 873-3500 | Unit Fax: (518) 873-3863 | After Hours Emergency 1-888-270-7249
132 Water Street | PO Box 217 | Elizabethtown, NY 12932 | www.co.essex.ny.us/Health