



# EARLY INTERVENTION PROGRAM REFERRAL FORM

**FAX THIS FORM TO THE APPROPRIATE OFFICE:**

**For a child with a suspected or known disability or delay—to the Regional Office of the child's residence**  
Bronx (718) 410-4504    Brooklyn (718) 722-2998    Manhattan (212) 487-7071  
Queens (718) 271-6114    Staten Island (718) 351-2585

**For an "at-risk" child—to the Child Find Unit**  
Citywide: (212) 227-3642

FOR OFFICE USE ONLY (Date of Referral)

Re-Open

CHILD'S NAME (Last)	(First)	(Middle)
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CHILD'S DATE OF BIRTH (MM/DD/YY) ____/____/____	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	RACE <input type="checkbox"/> White <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other, Specify: <input type="checkbox"/> Black <input type="checkbox"/> Alaskan/Native American	ETHNICITY <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic
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CHILD'S ADDRESS (Street, Apt No.)	BOROUGH	ZIP CODE
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MOTHER'S NAME (Last)	(First)	(Middle)
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MOTHER'S DATE OF BIRTH (MM/DD/YY) ____/____/____	LANGUAGES USED AT HOME	TELEPHONE <input type="checkbox"/> Home (____) ____ - ____ <input type="checkbox"/> Cell (____) ____ - ____ <input type="checkbox"/> Work (____) ____ - ____
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CAREGIVER'S NAME (Last) if different from above (First)	CHILD KNOWN TO ACS <input type="checkbox"/> Yes <input type="checkbox"/> No
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RELATION <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other, Specify:	CHILD KNOWN TO ACS <input type="checkbox"/> Yes <input type="checkbox"/> No
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CHILD'S DOCTOR	DOCTOR'S TELEPHONE (____) ____ - ____
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BIRTH HOSPITAL	LOCATION
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BIRTH WEIGHT <input type="checkbox"/> Pounds: ____ Ounces: ____ OR <input type="checkbox"/> Grams: ____	DIAGNOSIS if known:
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<p><b>REASON FOR REFERRAL (Check only ONE)</b></p> <p><input type="checkbox"/> This child is suspected or known to have a developmental delay or disability.</p> <p style="text-align: center;"><b>OR</b></p> <p><input type="checkbox"/> This child is developing typically at this time but may be at risk for atypical development. (Examples of this are: no prenatal care; maternal prenatal alcohol and/or substance abuse; NICU stay of 10 days or more; Elevated venous lead levels; Growth deficiency/nutritional problems; Homelessness; Concern regarding parent-child interaction; Parental developmental disability or mental illness).</p>	<p>Person Making Referral</p> <p>Address (Street, Apt No.)</p> <p>City, State, Zip</p> <p>Tel. (____) ____ - ____ Fax (____) ____ - ____</p> <p>Referring Agency/Facility</p> <p>Referral Source Type <input type="checkbox"/> Foster Care/ACS <input type="checkbox"/> Hospital <input type="checkbox"/> PCP <input type="checkbox"/> Parent/Family <input type="checkbox"/> Community Program <input type="checkbox"/> Other (Specify):</p>
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COMMENTS

Request for ISC		FOR OFFICE USE ONLY	
Requested SC	SC ID No.	ISC Request <input type="checkbox"/> Approved <input type="checkbox"/> Not Approved	Assigned SC
Agency	ID No.		SC ID No.
Tel. ( ) - Fax ( ) -			Tel. ( ) - Fax ( ) -
Reason for Request			Data Entry Date ____/____/____