NEW YORK STATE DEPARTMENT OF HEALTH
Early Intervention Program

Program Referral

CHILD'S COUNTY OF RESIDENCE: _____ **CHILD'S DATE OF REFFERAL:** (MM/DD/YYYY) _____ /_____ / _____

☐ **Section 1:** REQUIRED INFORMATION (By checking this box, the Municipality indicates they have received confirmation from the referral source that the parent/legal guardian was consulted, and did not object to the referral)

Child Information

CHILD'S NAME:

Last Name _____ First Name _____ Middle Name _____

SEX: ☐ Male ☐ Female

CHILD'S ADDRESS: (Street, Apt. No.) _____

DATE OF BIRTH: (MM/DD/YYYY) _____/ _____ /_____

DOMINANT LANGUAGE or MODE OF COMMUNICATION:

Child _____ Parent/Legal Guardian _____

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

RACE: (select more than one if appropriate)
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

REASON FOR REFERRAL: (Please only check ONE)

☐ **1. SUSPECTED** This child is being referred because he/she is suspected of having a developmental delay or disability.

☐ **2. CONFIRMED** This child is being referred because he/she has a confirmed disability (diagnosed physical or mental condition that has a high probability of resulting in developmental delay).

☐ **3. AT RISK** This child is **NOT** suspected of having a disability at this time but is being referred because he/she is **AT RISK** of having a disability (e.g., risk criteria identified in regulation, CAPTA referrals, etc.).

☐ **4. AT RISK** Infant did not pass newborn hearing screening and did not receive necessary follow-up.

Referral Source Information

REFERRAL SOURCE INFORMATION:

First Name: Caroline Last Name: Brabazon

Agency/Facility Name: Bridges to Bright Futures

Address: PO Box 6, Bellport, NY 11713

Telephone: (631) 286 - 0343 Ext. _____

Fax: (_____) _____ - _____

Email: referral@bridgestorbrightfutures.com

REFERRAL SOURCE TYPE: (Please only check ONE)

☐ Parent/Legal Guardian
☐ Other Family Member (Specify)_____
☐ Child Primary Healthcare Provider
☐ Hospital or Clinic
☑ Community Program/ EIP Provider
☐ Other (Specify)_____

Parent/Legal Guardian Contact Information

PARENT/LEGAL GUARDIAN NAME:

Last Name _____ First Name _____

Home: (____) _____ - _____ Cell: (____) _____ - _____

Work: (____) _____ - _____

Address:

Street, Apt. No. _____

City _____ Zip Code _____

PARENT/LEGAL GUARDIAN NAME:

Last Name _____ First Name _____

Home: (____) _____ - _____ Cell: (____) _____ - _____

Work: (____) _____ - _____

Address:

Street, Apt. No. _____

City _____ Zip Code _____

CAREGIVER/ALTERNATE CONTACT NAME:

Last Name _____ First Name _____

Telephone Number: (_____) _____ - _____

RELATIONSHIP TO CHILD:

☐ Grandparent Other: _____
☐ Foster Parent

CHILD'S NAME: _____ _____ **DATE OF BIRTH:** ____ / ____ / _____
Last Name First Name MM DD YYYY

Section 2: THE FOLLOWING INFORMATION REQUIRES INFORMED, WRITTEN PARENTAL CONSENT TO SHARE:

Informed Written Parent/Legal Guardian Consent Required

☐ **Referral Source confirms they have informed, written parental consent to include the following information and any attached documents.**

Referral Source Signature: _____

Referral Reason Additional Information:

Provide additional information about developmental concerns. Include any testing that has been completed and child's functioning in one or more developmental areas that may constitute a developmental delay that may establish the child's eligibility for the EIP.

Please check all functional areas that the child is demonstrating delays (include relevant comments or note if documents are attached):

☐ **Adaptive:** _____

☐ **Cognitive:** _____

☐ **Communication:** _____

☐ **Physical (gross and fine motor skills and includes vision, hearing, oral motor feeding and swallowing disorders):**

_____

☐ **Social-Emotional:** _____

☐ **Documentation is Attached:** _____

☐ **Diagnosed Condition(s) (include diagnosis /International Classification of Diseases (ICD-10) codes:**

_____

Additional Referral Details: _____

Parent/Legal Guardian's Signature: _____ **Date:** ____ / ____ / _____

Please note: If the fillable Referral Form includes a parent/legal guardian's electronic signature for consent to attach child records/reports, **that signature must also include an electronic signature validation marker (available through applications like Adobe Acrobat, DocuSign etc.) that includes the signature date and time on the form.** If that safeguard is not available and a parent/legal guardian signature is needed for Section 2, the Referral Form must be **printed** to allow the parent/ legal guardian to sign for consent on the paper copy.

☐ With parent's informed written consent, please ATTACH RECORDS or REPORTS that would assist in determining eligibility for the Early Intervention Program.

Office Use Only

FOR OFFICE USE ONLY

Date Referral Received: ____ / ____ / _____ ISC Requested: _____ Assigned ISC: _____

ISC Agency and Phone: (____) _____- _____ Date of ISC Assignment: ____ / ____ / _____

Data Entry Date: ____ / ____ / _____ Due Date for IFSP: ____ / ____ / _____

*Please see instructions when completing this form. Form can be mailed, faxed, or delivered to the Early Intervention Program in the child's county/municipality of residence.

Program Referral Instructions and Information

Age Requirements for Referrals:

Referrals for the Early Intervention Program (EIP) should be made for children less than 3 years of age. If a child is referred less than 45 days from their third birthday and is potentially eligible for services under Section 4410 of Education Law, the Early Intervention Official (EIO), with written parental consent, will refer the child to the Committee on Preschool Special Education (CPSE) of the local school district in which the child resides. The EIO is not required to conduct an evaluation, assessment, or an initial Individualized Family Service Plan (IFSP) meeting for a child referred within 45 days of their third birthday.

SECTION 1:

Contains fields that must be completed when making a referral to the local EIP. Referral form *may* be submitted after completing Section 1 with ONLY Section 1 information. Parental consent is not required to submit the information in Section 1. Parents must be informed of the intent to refer and if a parent objects, the referral cannot be made.

See Appendix 1: What to do When Parent/Legal Guardian Objects to Referral

Please write legibly or type all referral information.

Child's County of Residence:

Write the county in which the child resides. This will be the county where the EIP referral is sent.

Date of Referral:

This is the date that the referral source is submitting the referral to the local EIP. It is important that the referral date is accurate.

Child Information

Child's Name:

Include the child's full name in the spaces provided (Child's Last Name, Child's First Name, and Child's Middle Name). Please ensure that the spelling of the child's name is accurate. Do not use nicknames.

Date of Birth:

Child's date of birth formatted MM/DD/YYYY.

Child and Parent/Legal Guardian Dominant Language or Mode of Communication:

Write the dominant language or mode of communication of the child and parent/legal guardian.

Sex:

Check the box indicating the child's sex (male or female).

Child's Address:

Include the child's full address (including any apartment numbers), city, and zip code + 4.

Ethnicity and Race:

Check the appropriate box for each section. More than one racial designation for a child can be selected.

Reason for Referral:

In this section, you will be selecting the reason that you are making the referral to the EIP. It is important that you **select only ONE reason**.

1. **Suspected of Having a Disability:**
   Referral source suspects that the child being referred has a disability/developmental delay in one or more functional areas (adaptive, cognitive, communication, physical (including vision, hearing, oral motor feeding and swallowing disorders), and social-emotional) of development. Referrals for children suspected of having a disability (including a developmental delay) shall be based on:
   A. The results of a developmental screening or diagnostic procedure(s), direct experience, observation, and perception of the child's developmental progress;
   B. Information provided by a parent which is indicative of a developmental delay or disability;
   C. Or a request by a parent that such referral be made.

   Note: Infants who have not passed their inpatient newborn hearing screening prior to discharge from the hospital and failed any outpatient infant hearing screening are referred to the EIP as suspected of having a disability, in order to obtain either a rescreening or a confirmatory (diagnostic) hearing test at the audiologist's discretion. An infant suspected of having a hearing loss should have a diagnostic audiological evaluation prior to 3 months of age.

2. **Confirmed Disability:**
   The child is being referred to the EIP because they have a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.
   See Appendix 2: Diagnosed physical and mental conditions with a high probability of developmental delay

Developmental Monitoring (Child Find System)

3. **At Risk:**
   The child does not have a diagnosed disability and the referral source does not suspect that the child has a disability currently. The child is being referred for **developmental monitoring** because the child is **at risk** of having a disability.
   See Appendix 3: Referrals of children at risk of having a disability shall be made based on the following medical/biological or early childhood risk criteria
   - Child Abuse Prevention and Treatment Act (CAPTA) Referrals: Children who are referred to the EIP under the Federal CAPTA, who are not suspected of delay or have a diagnosed condition with a high probability of delay, would be referred as **At Risk**.

4. **At Risk Due to Failed Newborn Hearing Screening:**
   Infants are also referred to the at-risk category if the infant did not pass their newborn hearing screening and have not had necessary follow-up in a timely manner or documentation is missing under the Early Hearing Detection and Intervention (EHDI) Program.

Referral Source Information

Referral Source:

- Contact information for the individual who is making the referral.
- First Name and Last Name in spaces provided.
- Include agency or facility if the individual works for an agency.
- Include address.
- Include a phone number (including extension) and fax number that the referral source can be reached at if needed.
- Include email to be used to reach the referral source if needed. Please note, protected health information (PII) should not be included in email correspondence. See the *Dear Colleague Letter - Clarification to Early Intervention Providers on Parental Consent to Use E-mail to Exchange Personally Identifiable Information,* in **Additional Early Intervention Program (EIP) Referral Information/Resources** for more information.

See Appendix 4 for All Primary Referral Sources

Referral Source Type: (select only ONE) that fits best from the list below

- **Parent/Legal Guardian**
  - Parent
  - Friend/Relative (specify) if person is legal guardian
- **Other Family Member (Specify)**
  - Friend/Relative (specify) if **NOT** legal guardian
- **Child Primary Healthcare Provider**
  - Physician/Pediatrician
- **Hospital or Clinic**
  - Hospital
  - Healthcare Provider
  - Newborn Hearing Screening
  - Public/Community Health Facilities (clinic at local health department)
- **Community Program/EIP Provider**
  - Child Find
  - Day Care Provider
  - EIP Provider
  - Head Start Program
  - In House/Municipality staff
  - School District AKA Local Education Agency
  - Screening and Monitoring (At Risk)
- **Other (Specify)**
  - Friend / Relative (specify) if friend
  - Social Service Agencies
  - Other (specify)

Parent/Legal Guardian Information

Parent/Legal Guardian Information:

- Please fill out the information completely.
- Please make sure at least one parental/legal guardian contact information is included and completely filled out.
- Include the last name and first name of each parent/legal guardian in the spaces provided, as well as the address and phone numbers that the parent(s)/legal guardian(s) can be contacted at.
- If applicable, include the person in parental relation to the child.

Caregiver/Alternate Contact Name:

When necessary and applicable, include the name and contact information of another person through whom the parent may be contacted.

Relationship to Child:

Check the box for the accurate relationship of this individual to the child.

Child's Name:

Include child's full name (Child's Last Name and Child's First Name). Do not use nicknames.

Child's Date of Birth:

Child's date of birth formatted MM/DD/YYYY.

SECTION 2:

This section can only be completed, and the information submitted, if the parent/legal guardian has provided written consent to include this information.

Check the box and sign to attest that you have received **written parental consent** to include the information in **Section 2** of this referral form and attach any additional medical or other records which may be used to establish the child's eligibility for the EIP.

The evaluation agency selected will use the referral information and any attached medical records to determine the type of evaluation necessary. It is important that comprehensive information is included with this referral (with written parental/legal guardian consent). The evaluation agency will determine if a comprehensive screening, and/or multidisciplinary evaluation (MDE), or assessment is needed to determine eligibility for the EIP.

Referral Reason Additional Information:

This section includes any information that has been collected about the child that supports the reason that the child is being referred to the EIP.

Provide additional information about developmental concerns (including any testing that has been completed) and child's functioning in one or more developmental areas that may constitute a developmental delay that may establish the child's eligibility for the EIP.

Functional Areas:

Select the functional area(s) that the referral source has identified that the child is demonstrating a developmental delay.

- Adaptive
- Cognitive
- Communication
- Physical (gross and fine motor skills and includes vision, hearing, oral motor feeding and swallowing disorders)
- Social-Emotional

Include any comments related to identified delays or note that the document has been attached.

Diagnosed Condition(s) and International Classification of Diseases (ICD-10) Codes:

Referral source should specify the child's diagnosed condition and include the International Classification of Diseases (ICD-10) diagnosis code that is appropriate to the child. More than one diagnosed condition and ICD-10 code can be included on the referral form.

See Appendix 5

NOTE: The primary referral source is responsible for informing the parent of a child with a diagnosed condition that has a high probability of resulting in developmental delay, or a diagnosed developmental delay consistent with EIP eligibility requirements of the following:

1. Eligibility for the EIP is determined by a multidisciplinary evaluation (MDE).
2. The importance of providing written consent for the primary referral source to transmit records or reports necessary to support the diagnosis, or, for parents or guardians of children who do not have a diagnosed condition, records or reports that would assist in determining eligibility for the program.

With parental/legal guardian informed written consent:

Please attach any medical or other records/reports that would assist in determining a child's eligibility for the EIP.

Parent/Legal Guardian's Signature and Date:

Please note: If the fillable Referral Form includes a parent/legal guardian's electronic signature for consent to attach child records/reports, **that signature must also include an electronic signature validation marker (available through applications like Adobe Acrobat, DocuSign etc.) that includes the signature date and time on the form.** If that safeguard is not available and a parent/legal guardian signature is needed for Section 2, the Referral Form must be **printed** to allow the parent/ legal guardian to sign for consent on the paper copy.

This signifies the parent/legal guardian's informed written consent to transmit their child's medical information to the EIP.

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This section is completed by the receiving county.

Additional Early Intervention Program (EIP) Referral Information/Resources:

New York State Regulation and Public Health Law regarding Early Intervention Program Referrals: Title II-A of Article 25 of the Public Health Law: https://www.nysenate.gov/legislation/laws/PBH/A25T2-A and 10 NYCRR Section 69-4.3: Referrals: https://regs.health.ny.gov/book/export/html/48709

Dear Colleague Letter - Clarification to Early Intervention Providers on Parental Consent to Use E-mail to Exchange Personally Identifiable Information:
This document includes information on use of E-mail in the EIP: https://www.health.ny.gov/community/infants_children/early_intervention/memoranda/2009-10_early_intervention_parent_consent_to_use_email.htm

Early Intervention Memorandum 94-3: Referral Procedures for the Early Intervention Program Reissued< MM/YYYY>. This document includes specific information regarding making referrals: https://www.health.ny.gov/guidance/oph/cch/bei/94-3.pdf

Where to send a referral:
Referrals must be sent to the Early Intervention Official (EIO) in the county where the child currently resides. Primary Referral Sources may transmit referrals via U.S. mail or fax. A list of municipality/county contacts can be found at: https://www.health.ny.gov/community/infants_children/early_intervention/county_eip.htm

Information for Parents about the Early Intervention Program:
Early Intervention Program information for parents is located on the New York State (NYS) Department of Health Early Intervention Program website: https://www.health.ny.gov/community/infants_children/early_intervention/index.htm

The following brochures are available FREE of charge for NYS residents:
Early Help Makes a Difference! (brochure which highlights developmental milestones for children from birth to age three)

Early Intervention Steps: A Parent's Basic Guide to the Early Intervention Program (this booklet describes the Early Intervention Program)

Newborn Hearing Screening Brochures:

- *Can Your Baby Hear You?*
- *Your Baby Passed the Hearing Screening*
- *Your Baby Needs Another Screening*

Clinical Practice Guidelines (New York State Guidelines offer recommendations based on scientific evidence and expert clinical opinion on effective practices):

- *Autism/Pervasive Developmental Disorders- Assessment and Intervention for Young Children (Age 0-3 Years)*
- *Communication Disorders- Assessment and Intervention for Young Children (Age 0-3 Years)*
- *Down Syndrome- Assessment and Intervention for Young Children (Age 0-3 Years)*
- *Hearing Loss- Assessment and Intervention for Young Children (Age 0-3 Years)*
- *Motor Disorders- Assessment and Intervention for Young Children (Age 0-3 Years)*
- *Vision Impairment- Assessment and Intervention for Young Children (Age 0-3 Years)*

These resources are available electronically on the New York State Department of Health (NYSDOH) Early Intervention Program (EIP) website. These resources can be ordered free of charge to New York residents through the NYS DOH Distribution Center. The order form can be accessed on the NYSDOHEIP website or through the following link: https://www.health.ny.gov/forms/order_forms/eip_publications.pdf

Appendices

Appendix 1

What to do When Parent/Legal Guardian Objects to Referral

Primary Referral Source shall:

- Maintain written documentation of the parent's objection to the referral and follow-up actions taken by the primary referral source;
- Provide the parent with the name and contact information of the early intervention official (EIO) if the child is suspected of having a disability or if the child is at-risk;
- Within two months, make reasonable efforts to follow-up with the parent, and if appropriate, refer the child to the EIP unless the parent objects.

Appendix 2

Diagnosed physical and mental conditions with a high probability of developmental delay include: (10 NYCRR 69-4.3(f))

- Chromosomal abnormalities associated with developmental delay (e.g., Down syndrome)
- Syndromes and conditions associated with delays in development (e.g., fetal alcohol syndrome)
- Neuromuscular disorder (e.g., any disorder known to affect the central nervous syndrome, including cerebral palsy, spina bifida, microcephaly, or macrocephaly)
- Clinical evidence of central nervous system (CNS) abnormality following bacterial/viral infection of the brain or head/spinal trauma
- Hearing impairment (a diagnosed hearing loss that cannot be corrected with treatment or surgery)
- Visual impairment (a diagnosed visual impairment that cannot be corrected with treatment (including glasses or contact lenses or surgery)
- Diagnosed psychiatric conditions (e.g., reactive attachment disorder of infancy and early childhood)
- Emotional/behavioral disorder

Appendix 3

Referrals of children at risk of having a disability shall be made based on the following medical/biological or early childhood risk criteria:

Neonatal Risk Criteria	Post-Neonatal Risk Criteria	Other Risk Criteria
• Birth weight 1000-1501 grams • Gestational age less than 33 weeks • Central nervous system insult or abnormality (including neonatal seizures, intracranial hemorrhage, need for ventilator support for more than 48 hours, birth trauma) • Congenital malformations • Asphyxia (Apgar score of 3 or less at 5 minutes) • Abnormalities in muscle tone (hypertonicity or hypotonicity) • Hyperbilirubinemia (> 20mg/dl) • Hypoglycemia (serum glucose under 20 mg/dl) • Growth deficiency/nutritional problems (e.g., small for gestational age; significant feeding problem) • Presence of Inborn Metabolic Disorder (IMD) • Perinatally or congenitally transmitted infection (e.g., HIV, hepatitis B, syphilis) • 10 or more days hospitalized in a Neonatal Intensive Care Unit (NICU) • Maternal prenatal alcohol abuse • Maternal prenatal abuse of illicit substances • Prenatal exposure to therapeutic drugs with known potential developmental implications (e.g., psychotropic medications, anticonvulsant, antineoplastic) • Maternal PKU • Risk of hearing loss based on family history including syndromal presentation or failure of initial newborn infant hearing screening and the child needs follow-up screening. • Risk of vision impairment including family history of conditions causing blindness or severe vision impairment • Present of a genetic syndrome that may confer increase risk for developmental delay	• Parent or caregiver concern about developmental status • Serious illness or traumatic injury with implications for central nervous system development and requiring hospitalization in a pediatric intensive care unit for 10 or more days • Elevated venous blood levels (at or above 15 mcg/dl) • Growth deficiency/nutritional programs (e.g., significant organic or inorganic failure-to-thrive, significant iron-deficiency anemia • Chronicity or serious otitis media (continuous for a minimum of 3 months) • HIV infection • Indicated case of child abuse or maltreatment	• No prenatal care • Prenatal developmental disability or diagnosed serious and persistent mental illness • Parental substance abuse • No well child care by 6 months of age or significant delay in immunizations • Other risk criteria identified by the primary referral source

Appendix 4

Primary Referral Sources

The following primary referral sources shall, within **two working days** of identifying an infant or toddler who is less than three years of age and suspected of having a disability or at risk of having a disability, refer such infant or toddler to the official designated by the municipality, unless the child has already been referred or unless the parent objects:

- All individuals who are qualified personnel who deliver services to the extent authorized by their licensure, certification or registration
- All approved evaluators, service coordinators, and providers of early intervention services
- Hospitals
- Child health care providers
- Daycare programs
- Local health units (local health department)
- Local school districts
- Local social service districts including public agencies and staff in the child welfare system
- Public health facilities
- Domestic violence shelters and agencies
- Homeless family shelters
- Operators of any clinic approved under Article 28 of Public Health Law, Article 16 of the Mental Hygiene Law, or Article 31 of the Mental Hygiene Law

Appendix 5

A current list of *International Diagnosed Conditions Codes (ICD-10 Codes)* and their designation as a qualifying diagnosed condition with a high probability of resulting in developmental delay for use in determining eligibility for the Early Intervention Program is maintained and can be accessed on the Health Commerce System (HCS) in the State Early Intervention Data System.

For those who do not have access to HCS and the State Early Intervention Data System, this information can also be accessed through the State Fiscal Agent's (PCG) website: www.eibilling.com. The most recently updated list of ICD Codes can be found using the search feature in the Knowledge Base tab on the website.