NEW YORK STATE DEPARTMENT OF HEALTH
Early Intervention Program

Referral Form for Children At-Risk or Suspected of Developmental Delay or Disability or With a Confirmed Disability

Instructions: This form may be used to refer a child under three years of age who is at risk for or suspected of having a developmental delay or disability or has a confirmed disability. The referral must be made via telephone, facsimile, or mail to the Early Intervention Official in the child's county of residence within two working days of the child's identification.

Report Date ☐☐ mo ☐☐ day ☐☐ yr

Referral Source

Person making referral	last	first	MI
Agency/Facility			
Address street		city	
state	zip	Telephone (☐☐☐) ☐☐☐ ☐☐☐☐	Ext. _____

Child's Information

Child's Name	last	first	MI
Also known as	last	first	MI
Child's Address street		city	
Birthdate ☐☐ mo ☐☐ day ☐☐ yr	Sex F ☐ M ☐	Dominant language used	
County of residence			

Family Information

Name of Parent(s) or Legal Guardian	last	first	MI	last	first	MI
Address street				city		
state	zip	Telephone (☐☐☐) ☐☐☐ ☐☐☐☐	Ext. _____			
Relationship to Child		Dominant language used				

Alternate Contact (Through Whom the Parent May Be Contacted)

Alternate name	last	first	MI
Relationship to child		Telephone (☐☐☐) ☐☐☐ ☐☐☐☐	Ext. _____

Reason for Referral (Please check [✔] only one)

☐ This child is being referred because he or she has a **confirmed** disability or is **suspected** of having a disability, which includes a developmental delay and/or a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

☐ This child is NOT suspected of having a disability at the present time but is being referred because he or she is **at risk** of developing a disability in the future.

(OVER)

Child's name (last / first / MI)	Birthdate (mo / day / yr)

THIS INFORMATION IS TO BE TRANSMITTED WITH INFORMED PARENTAL CONSENT*

Primary Health Care Provider	Telephone ( ) Ext.

STATUS AT TIME OF REFERRAL

Currently hospitalized: ___ NICU ___ PICU ___ Other ___ Facility Name: ___	___ Not hospitalized	Discharge date (mo / day / yr)

Diagnosed Conditions and/or Other Comments

Please specify

Suspected Delay (Please check [✔] all that apply)

- ☐ Cognitive
- ☐ Communication
- ☐ Adaptive
- ☐ Physical (including vision and hearing)
- ☐ Social/emotional

"At-Risk" Criteria (Check the box of each condition identified. Refer to Glossary of Risk Indicators. Copies may be obtained by contacting the Early Intervention Program at the New York State Department of Health at (518) 473-7016.)

Neonatal Risk Criteria

- ☐ Birth weight <1501 grams
- ☐ Gestational age <33 weeks
- ☐ CNS insult or abnormality
- ☐ Asphyxia (Apgar score of ≤ 3 at 5 minutes)
- ☐ Abnormalities in muscle tone
- ☐ Hyperbilirubinemia (>20 mg/dl)
- ☐ Hypoglycemia (<20 mg/dl)
- ☐ Growth deficiency/nutritional problems
- ☐ Inborn Metabolic Disorder (IMD)
- ☐ Perinatally - congenitally transmitted infection
- ☐ >10 days in Neonatal Intensive Care Unit (NICU)
- ☐ Maternal prenatal alcohol abuse
- ☐ Maternal prenatal abuse of illicit substances
- ☐ Prenatal exposure to certain therapeutic drugs with known potential developmental implications
- ☐ Maternal PKU
- ☐ Suspected hearing impairment
- ☐ Suspected vision impairment

Post-neonatal and Early Childhood Risk Criteria

- ☐ Parental/caregiver concern about developmental status
- ☐ Suspect score on developmental/sensory screening
- ☐ Serious illness/traumatic injury with implications for CNS
- ☐ Elevated blood lead levels (above 19 mcg/dl)
- ☐ Growth deficiency/nutritional problems
- ☐ Chronicity of serous otitis media (Continuous for minimum of 3 months)
- ☐ HIV infection

Other Risk Criteria that May Be Considered

- ☐ No prenatal care
- ☐ Parental developmental disability/mental illness
- ☐ Parental substance abuse
- ☐ No well child care by age 6 months
- ☐ Other, please specify ___

Parental/Legal Guardian Consent

I consent to the release of the above information to:

Name: ___

Title : ___

Early Intervention Official
Early Intervention Program

___
Signature

Date ___/___/___

County/municipality: ___

* Above signature may be used for parental consent purposes. Parental consent may also be obtained with an existing protocol or form routinely used by the referral source that legally authorizes transmittal of this information to the Early Intervention Program.