



State of Hawai'i Department of Health  
Early Intervention Section (EIS)

Oah'u: 808-594-0066  
Toll Free: 800-235-5477  
Fax: 808-594-0073

EARLY INTERVENTION (EI) REFERRAL FORM

**\*Required information for referral to be processed**

Call/Fax Date: \_\_\_\_\_  
MM/DD/YY

Referral Source Name: \_\_\_\_\_ Fax #: \_\_\_\_\_ Ph #: \_\_\_\_\_

Relationship to Child:  Parent  Physician  CWS Home Visiting  DOH Home Visiting  Early Head Start  
 Preschool/Childcare  Public Health Nursing  DHS-CWS  Other \_\_\_\_\_

Organization/Affiliation: \_\_\_\_\_

Address, include city & zip code (if not parent): \_\_\_\_\_

How Referral Source Became Aware of EI:  Brochure  Poster  Child Fair/Event Table  \_\_\_\_\_

**\*Child's Name:** \_\_\_\_\_ **\*Date of Birth:** \_\_\_\_\_  
First Last MM/DD/YY

Gender:  M  F Age: \_\_\_\_\_ years \_\_\_\_\_ months \_\_\_\_\_ weeks

Legal Guardianship:  Parent(s)  Other: \_\_\_\_\_ Phone: \_\_\_\_\_  
 CWS: SW Name: \_\_\_\_\_ Phone/Fax: \_\_\_\_\_

**\*Area(s) of Concern: (check all that apply)**

Developmental:  Adaptive  Cognitive  Communication  Fine Motor  Gross Motor  Social/Emotional

Medical:  Chrom. Ab.  Genetic/Congenital Disorder  Other: \_\_\_\_\_  
 Technology Dependent  Skilled Nursing Needed: Amount of Hours per week: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

Developmental and/or Medical Concerns: \_\_\_\_\_

**Screening/Assessments Done:**

ASQ  ASQ-SE  PEDS  M-CHAT  Denver  HELP  Other: \_\_\_\_\_  
 Newborn Hearing Screening Results: Left - Pass:  Yes  No Right - Pass:  Yes  No

**Agencies Working w/ Child:**  Child Welfare Services  Children w/ Special Health Needs Program  Early Head Start  
 CWS Home Visiting  DOH Home Visiting  Public Health Nursing  Other: \_\_\_\_\_

**\*Primary Caregiver Name(s):** \_\_\_\_\_

Relationship to Child:  mother  father  resource caregiver  guardian  other: \_\_\_\_\_

**\*Primary Caregiver Name(s):** \_\_\_\_\_

Relationship to Child:  mother  father  resource caregiver  guardian  other: \_\_\_\_\_

**\*Residence Address (include apt. #, city & zip code):** \_\_\_\_\_

Mailing/Other Address (include city & zip code): \_\_\_\_\_

**\*Phone # (h):** \_\_\_\_\_ **(c):** \_\_\_\_\_ **(c):** \_\_\_\_\_ **(w):** \_\_\_\_\_  
(primary) (secondary)

**(other):** \_\_\_\_\_ **Best Call Time:** \_\_\_\_\_ **Preferred Call Number:** \_\_\_\_\_

*My signature below provides consent for the Department of Health Early Intervention to share the status of the referral with the referral source.*

Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_