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

Oah'u: 808-594-0066
Toll Free: 800-235-5477
Fax: 808-586-0016

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:** _____ (First) _____ (Last) ***Date of Birth:** _____ 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:

***Child's Residence Address (include apt. #, city & zip code):** _____

***Legal Guardian's Mailing Address (include city & zip code), if different than child's residence:** _____

***Phone #** **(h):** _____ **(c):** _____ (primary) **(c):** _____ (secondary) **(w):** _____

(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:** _____

EI Referral Form
Instructions

NOTE: Use "TAB" key to move between fields – Do NOT use "ENTER" key

PUPRPOSE OF FORM
EI Referral Form is used by referral sources to submit a referral to Early Intervention when there is a concern about a child's development. The form is also used by the EI Referral Unit and EI Programs when a call in referral is received.

HOW TO COMPLETE THIS FORM
Call/Fax date: Enter the date call received or date form is faxed to EI Referral Line.
Referral Source Name: Enter the name of the person making the referral. NOTE: If someone is making the referral on another person's behalf (e.g., Nurse for Doctor), enter the person who requested initiating the referral (e.g., Doctor).
Fax #: Enter fax number of referral source, including area code if other than 808.
Ph #: Enter phone number of referral source, including area code if other than 808.
Relationship to Child: Select the most appropriate box. Other options is as follows: (write in if not listed)

DOE	Other Clinic	Other Public Health Provider
Domestic Violence Agency	Other Family Member	Other Social Service Provider
Domestic Violence Shelter	Other Healthcare Provider	Resource Caregiver (Foster Parent)
Homeless Family Shelter	Other Public Health Agency	

NOTE: DHS VCM & FSS, select "Other Social Service Provider" and indicate VCM of FSS after Program Name.
Organization/Affiliation: Enter the name of Organization/Affiliation (e.g. Name of Hospital, Name of Program, etc.)
Address, include city & zip code (if not parent): Enter Organization/Affiliation address
How Referral Source Became Aware of EI: If this is your first time referring to EI, please select the most appropriate box.

*Child's Name: Enter child's legal name (first and last name)
*Date of Birth: Enter child's date of birth
Gender: For boys, select "M" and for girls, select "F"
Age: Enter year, months, and weeks
*Legal Guardian: Select the most appropriate box. For "other" and "CWS," include the name of the guardian.
Phone: enter phone number of legal guardian
Phone/Fax: enter phone number and fax number of Child Welfare Services (CWS) Social Worker (SW)
*Areas(s) of Concern: Select all that apply
Diagnosis: Enter diagnosis, if known
ICD code: Enter ICD-9 or ICD-10 (effective 10/1/15) code
Developmental and/or Medical Concerns: write a brief description of any concerns
Screening/Assessment Done: Select any screenings/assessments completed. NOTE: If known, please include results of the Newborn Hearing Screening.
Agencies Working w/ Child: Select all that apply

*Primary Caregiver Name(s): Enter primary caregiver name(s)
Relationship to Child: Select the most appropriate box that best describes the primary caregiver's relationship to the child.
*Child's Residence Address (include city & zip code): Enter address of the primary caregiver.
*Legal Guardian's Mailing Address (include appt. #, city & zip code), if different than child's residence: Enter mailing address if different than residence address of the primary caregiver. NOTE: If homeless, include general vicinity/relative's address and contact number.
*Phone #: enter home (h), cell (c), work (w), and other number(s)
Best Call Time: Enter the best time to call the primary caregiver
Preferred Call Number: Enter the preferred phone number for the primary caregiver.

Signature of the Legal Guardian allows the EI Program to share the status of the referral with the referral source.
Date: Enter date signature was obtained.

*Required information for a referral to be considered a complete.