

**State of Hawai‘i Department of Health**

##### Early Intervention Section (EIS)

**Oahu: 808-594-0066**

**Toll Free: 800-235-5477**

**Fax: 808-586-0016**

# EARLY INTERVENTION (EI) REFERRAL FORM

|  |
| --- |
| **NOTE: Use “TAB” key to move between fields – Do NOT use “ENTER” key** |
| **\*Required information for referral to be processed** |  **Call/Fax Date:** |       |
|  |  |  |  |  | MM/DD/YY |
|  |  |  |  |  |  |
| **Referral Source Name:** |       | **Fax #:** |       | **Ph #:** |       |
|  |  |  |
| **If parent inquires, the Referral Source consents to sharing their: (check all that apply)** [ ]  **name** [ ]   **phone number**  |
|  |  |  |
| **Relationship to Child:** | [ ]  **Parent** | [ ]  **Physician** | [ ]  **DHS-CWS** | [ ]  **CWS Home Visiting**  | [ ]  **DOH Home Visiting** | [ ]  **Early Head Start** |
| **[ ]  Preschool/Childcare** | [ ]  **Public Health Nursing** [ ]  **WIC** | [ ]   |  |
|  |
| **Organization/Affiliation:** |       |
|  |  |
| **Address, include city & zip code** (if not parent): |       |
|  |
| **How Referral Source Became Aware of EI:** **[ ]  Brochure** **[ ]  Poster** **[ ]  Child Fair/Event Table** | **[ ]  Other** |       |
|  |
|  |
|  |
| **\*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:  | s      | 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):** |       | **(c):** |       | **(w):** |       |
|  |  | (primary) |  | (secondary) |  |  |  |
| **(other):** |       | **Best Call Time**: |       | **Preferred Call Number:** |       |
|  |
|  |
| **Additional Comments:** |       |
|       |
|  |
|  |
| ***My signature below provides consent for the Department of Health Early Intervention to share the status of the referral with the referral source.*** |
| **Parent/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 phone 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.

If parent inquires, Referral Source consents to…: check name and/or phone number option to indicate consent.

Relationship to Child: Select the most appropriate box. Other options is as follows: (write in if not listed)

DOE

Domestic Violence Agency

Domestic Violence Shelter

Homeless Family Shelter

Other Clinic

Other Family Member

Other Healthcare Provider

Other Public Health Agency

Other Public Health Provider

Other Social Service Provider

Resource Caregiver (Foster Parent)

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.