Westchestergov.com Early Intervention Program Referral Form

Referral Date:_____

Fax: (914) 813-4452
Phone: (914) 813-5094

Section 1. REQUIRED INFORMATION

CHILD'S NAME: (Last, First, Middle)			DATE OF BIRTH: MM/DD/YYYY / /
SEX ☐ Male ☐ Female	CHILD'S ADDRESS: (Street, Apt #)	CITY:	Zip Code:
RACE (may select more than one if applicable) ☐ White ☐ Asian ☐ Black ☐ Native American or Alaskan ☐ Hawaiian or Pacific Islander		ETHNICITY: ☐ Hispanic ☐ Not Hispanic	
Parent/Guardian: _____ Relation to Child: ☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Other, Specify		**TELEPHONE:** Home: ( ) Cell: ( ) Work: ( )	
Alternate Contact: _____ Telephone: ( ) _____ Relation to Child: ☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Other, Specify		DOES FAMILY NEED INFORMATION IN ANOTHER LANGUAGE: [ ] NO [ ] YES, INDENTIFY:	

Person Presenting Referral to Early Intervention

NAME:		AGENCY or FACILITY, if any:	
ADDRESS: (Street, Apt #)	CITY:	STATE:	Zip Code:
TELEPHONE: ( ) _____	FAX: ( ) _____		
Referral Source: ☐ Community Program or EI Agency ☐ Parent/Family ☐ Foster Care ☐ Primary Health Care Physician ☐ Hospital ☐ Other, Specify _____			

Reason for Referral (Check Only One)

☐ **EARLY INTERVENTION: Child with a suspected or known developmental delay or disability OR Child who missed or failed Newborn Hearing Screening.**

☐ **DEVELOPMENTAL MONITORING/SURVEILLANCE by the Public Health Nurse: Child is developing typically but may be "at risk" for atypical development.**

Comments:

Section 2. WITH INFORMED PARENTAL CONSENT

PRIMARY CARE PHYSICIAN:		PHONE:
BIRTH HOSPITAL:	LOCATION:	
BIRTH WEIGHT: *Pounds:* _____ *Ounces:* _____ **OR** *Grams:* _____	Gestational Age: _____*weeks*	DIAGNOSIS *if known:*

FOR USE BY WCDH STAFF ONLY:
COMMENT: _____