Early Intervention Program Referral Form

NORTH REGION

Please complete this form for referring a child to Early Intervention (Part C) if you prefer to do so in writing.
Also please indicate the feedback that you want to receive from the Early Intervention Program in response to your referral. Diagnosis of a specific condition or disorder is not necessary for a referral ***however***, children must show a 50% delay in 1 area or a 25% delay in 2 areas of development to qualify for early intervention services.

Parent/Child Contact Information

Child's Name:		**Interpreter Needed:**	☐ Yes	☐ No			
Date of Birth:		**Child's Age (Months):**		**Gender:**	☐ M	☐ F	**Race:**
Home Address:							
Parent/Guardian:		**Relationship to Child:**					
Primary Language:		**Home Phone:**		**Other Phone:**			
Second Contact:		**Relationship to Child:**		**Phone Number:**			
Emergency Contact:		**Relationship to Child:**		**Phone Number:**			

Reason(s) for Referral to Early Intervention – Please check all that apply

☐	**Identified condition or diagnosis (ex. Spina Bifida, PKU, etc.):**				
☐	**Suspected developmental delay or concern: (please check area of concern)**	☐ Motor/Physical	☐ Cognitive	☐ Social/Emotional	
		☐ Speech/Language	☐ Behavior	☐ Vision	☐ Hearing
Newborn Hearing Screen Referral:		☐ Passed	☐ Failed		
Other (Describe):					

Referral Source Contact Information

Referring Agency:			
Contact Name:		**Date of Referral:**	
Address:			
Office Phone:	**Office Fax:**	**Email:**	

Feedback Requested by the Referral Source

Date Referral Received:		**Date of Initial Appt. with Child/Family:**	
Name of Assigned Service Coordinator:			
Office Phone:	**Office Fax:**	**Email:**	
After initial appt., please send the following information (check all that apply):			
☐ Status of Initial Family Contact	☐ Family Declined Services	☐ Developmental Evaluation Results	
Eligibility Status: ☐ Eligible	☐ Not Eligible		
Other (Describe):			

Release of Information Consent (OPTIONAL)

I, *(Name of parent/guardian),* give permission for my pediatric health care provider and/or Early Intervention Services, *(Provider's name),* to share any and all pertinent information regarding my child *(Child's name).*

Parent/Guardian Signature:		**Date:**	

Early Intervention Program Contact Information-North

Nevada Early Intervention Referral Line	**Phone: 775-688-1341**	**Fax: 775-688-2984**

NEIS USE ONLY

EI Program:			**R.S.**		
EI Code #:	**Date:**		**Medical Records:**	☐ Yes	☐ No

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