

Early Intervention Program Referral Form

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:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of Birth:	Child's Age (Months):	Gender:	<input type="checkbox"/> M <input type="checkbox"/> 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

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

Referral Source Contact Information

Referring Agency: Project ASSIST	
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):			
<input type="checkbox"/> Status of Initial Family Contact		<input type="checkbox"/> Family Declined Services <input type="checkbox"/> Developmental Evaluation Results	
Eligibility Status: <input type="checkbox"/> Eligible <input type="checkbox"/> Not Eligible			
Other (Describe):			

Release of Information Consent (OPTIONAL)

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

Early Intervention Program Contact Information

Nevada Early Intervention Referral Line	Phone: 800-522-0066	Fax: 775-687-0599	Email: ProjectAssist@dhs.nv.gov
NEIS USE ONLY			
EI Program: 0	R.S.		
EI Code #:	Date:	Medical Records:	<input type="checkbox"/> Yes <input type="checkbox"/> No

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