Clinton County Health Department
133 Margaret Street, Plattsburgh, New York 12901-2926
"Working Together for a Healthier Community"
www.clintonhealth.org

Public Health
Prevent. Promote. Protect.

Health Care Services Division **Phone: (518) 565-4848** **Fax: (518) 565-4509**

EARLY INTERVENTION REFERRAL FORM

CHILD'S INFORMATION:

Name:_____ DOB:_____Sex: _____
Last First MI

Parent/Guardian:_____ Phone:_____

Alternate Phone(s)_____Ethnicity/Race_____

Address:_____ County of Residence_____

Foster Child: ☐ Yes (County)_____☐ No

Alternate Contact:_____Phone: _____

AT RISK CRITERIA:

Referrals of children at-risk of having a disability shall be made based on the following medical/biological risk factors:

- ☐ Birth weight less than 1501 grams
- ☐ Maternal PKU
- ☐ Gestational age <33 weeks
- ☐ CNS Insult/abnormality
- ☐ Asphyxia (5 min. Apgar <4)
- ☐ Congenital malformations
- ☐ Hyper or hypotonicity
- ☐ Hyperbilirubinemia above 20 mg/dl)
- ☐ Hypoglycemia (serum glucose less than 20 mg/dl)
- ☐ Growth deficiency/nutritional problems at birth (eg, SGA, IUGR)
- ☐ Growth deficiency/nutritional problems early childhood (eg, FTT)
- ☐ Presence of Inborn Metabolic Disorder
- ☐ Prenatally/congenitally transmitted infection (e.g., HIV, hep B, syphilis)
- ☐ NICU stay of 10 days or more
- ☐ Prenatal exposure to therapeutic drugs with known risk
- ☐ Maternal prenatal drug or alcohol abuse
- ☐ No well-child care by 6 months
- ☐ Parental concern re-development
- ☐ Questionable score on develop-mental screen
- ☐ Illness/trauma with CNS implications and ICU >10 days
- ☐ Venous lead level >9 mcg/dl
- ☐ Serous Otitis Media >3 months
- ☐ HIV Infection
- ☐ No prenatal care
- ☐ Parental developmental disability in mental illness
- ☐ Significant immunization delay
- ☐ **Genetic Syndrome**
- ☐ Failed initial hearing screening
- ☐ Suspected vision/hear impairment
- ☐ Other risk criteria as identified by the primary referral source:

CONFIRMED OR SUSPECTED DELAY OR DISABILITY:

Functional area(s) of Suspected Delay:

- ☐ Adaptive
- ☐ Cognitive
- ☐ Communication
- ☐ Social/Emotional
- ☐ Physical

Referrals may also be based on a diagnosed physical and/or mental condition with a high probability of developmental delay contained in New York State Department of Health's list at

www.health.state.ny.us/community/infants_children/early_intervention/index/htm

then click on Memorandum Guidance and Clinical Practice Guidelines [in the box to the left]

then click on Memorandum 2005-2 [Section V contains the list]

_____

☐ Other reason for referral: _____

Comments/Additional Information:_____

_____

Referred by:_____Title:_____Date of Referral
_____Address:_____Telephone:_____

For Office Use Only:

Date Referral Received:_____by EIO (D) Child Find assigned: _____Date:_____

Initial Service Coordinator Assigned: _____Date:_____NYEIS # _____

"Persons who have any physical mobility or other needs, call the telephone number above to arrange for accommodations"

EARLY INTERVENTION REFERRAL FORM FOLLOW-UP CONTACTS

Follow up Contacts:

Date:_____ _____

Time: _____ _____

_____

_____

_____

Date:_____ _____

Time: _____ _____

_____

_____

_____

Date:_____ _____

Time: _____ _____

_____

_____

_____

Date:_____ _____

Time: _____ _____

_____

_____

_____

"Persons who have any physical mobility or other needs, call the telephone number above to arrange for accommodations