Illinois Early Intervention Program
Referral Fax Back Form

PART 1 of 2

Complete Part I upon contacting the family, or when a family cannot be contacted in a timely manner. Send Part I completed to the primary care provider listed in the Standardized Illinois Early Intervention Referral Form to inform them about the referral outcome.

Date: ____/____/____

Child's Name: _____ **DOB**: ____/____/____

Parent/Guardian Name: _____

Date Referral Received: ____/____/____

This child was referred to our Child and Family Connections office. The following is the status of that referral:

☐ The family was contacted on (date): ____/____/____

☐ A Service Coordinator has been assigned to the family:

Name: _____

CFC # / Location: _____ / _____

Phone Number: _____ - _____ - _____ Fax Number: _____ - _____ - _____

E-Mail: _____

☐ Repeated attempts have been made to contact this family - we were unable to establish contact.
Date final contact attempt made: ____/____/____
Please let us know if the family is still interested in having an evaluation for their child.

☐ The family has been contacted and requests that you contact them directly for results.
Date request made by family: ____/____/____

☐ The family has declined services at this time.
Date service declined: ____/____/____

Additional comments:

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PART 2 of 2

To be completed after eligibility is determined and the Individualized Family Service Plan (IFSP) is completed to inform the primary care provider about Early Intervention eligibility, other referrals provided, and Early Intervention services recommended, if eligible.

NOTE: Information can be released to the provider identified in Section 6, Authorization to Release Information, in the Standardized Illinois Early Intervention Referral Form. The parent(s) or legal guardian must sign a separate consent form in order to send the information shown below to an entity other than the referral source listed in Section 6 of the Standardized Illinois Early Intervention Referral Form.

Date: ____/____/____

Child's Name: _____ **DOB**: ____/____/____

Parent/Guardian Name: _____

1. ☐ The family has been contacted and the following has occurred:
   - ☐ The child has been evaluated and found to be **not eligible** for services at this time (Skip to #4).
   - ☐ The child has been evaluated and found to be **eligible** for services based on the following:
     - ☐ 30% or greater developmental delay
     - ☐ Qualifying Diagnosis of: _____
     - ☐ Other: _____

2. ☐ The child and family have been recommended to receive the following Early Intervention services:
   - ☐ Developmental Therapy
   - ☐ Occupational Therapy
   - ☐ Physical Therapy
   - ☐ Speech Therapy
   - ☐ Social Work/Counseling
   - ☐ Other: _____
   - ☐ Notes: _____

3. ☐ An IFSP was/will be developed for the child and family. The IFSP Summary Report will be released to the provider identified in Section 6, Authorization to Release Information, in the Standardized Illinois Early Intervention Referral Form (a full copy of the plan may be obtained through the contact listed in Part I).

4. ☐ The child and family received referrals to the following non-EI services: _____

   _____

5. ☐ The evaluation/assessment and service planning process have not been completed because:

   _____

Additional comments: