Standardized Illinois Early Intervention Referral Form

Please complete Sections 1 through 6 of this form to refer a child to Early Intervention (EI) for eligibility determination.

Section 1. Child Contact Information

Child Name: _____ AKA_____

Date of Birth: _____/_____/_____ Child Age: _____ Gender: M F Race: _____

Street Address: _____

City: _____State: _____ Zip: _____ County: _____

Type of Insurance Coverage: □ Medicaid □ Private Insurance

Parent/Guardian Name: _____ Relationship to Child: _____

Primary Language: _____ Home Phone: _____/_____-_____ Other Phone: _____/_____-_____

Alternate or Emergency Contact Person: _____Phone: _____/_____-_____

Section 2. Reason(s) for Referral

Reason(s) for referral to EI (Please check all that apply):

☐ Identified condition or medical diagnosis (e.g., spina bifida, Down syndrome): _____

☐ Suspected developmental delay based on objective developmental screening using (please note screening tool used) _____ (Please check area[s] of concern):

___Motor/Physical ___Cognitive ___Social/Emotional ___Speech ___Language/Communication

___Behavior ___Vision/Hearing ___Adaptive/Self-help Skills ____Other, specify_____

Comments: _____

☐ At Risk (Please describe risk factors): _____

☐ Other (Please describe): _____

☐ Family is aware of reason for referral

Section 3. Referral Source Contact Information

☐ **Check here if Primary Care Provider (PCP) is source of referral** and s**kip Section 3** and **complete Section 4**

Referral Date: _____/_____/_____

Name of Agency Making Referral: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone: _____/_____-_____ Office Fax: _____/_____-_____ E-mail: _____

Contact Person at Referral Site: _____

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Section 4. Primary Care Provider Contact Information

Referral Date: _____/_____/_____

Name of Child's Primary Care Provider: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone: _____/_____-_____ Office Fax: _____/_____-_____ E-mail: _____

Contact Person at Primary Care Provider Office: _____

CFC Office, please send the following checked items:

- ☐ Date the family was contacted and outcome of the contact
- ☐ Eligibility for services and a list of services the child is eligible for
- ☐ A summary of the Individualized Service Plan (IFSP)
- ☐ Other referrals provided by EI to the child/family

Section 5. Early Intervention CFC Office Referral Location

Using the attached list of CFC Offices, insert the CFC number where the child is being referred:
CFC #: _____

Section 6. Authorization to Release Information

1. **Referral to Early Intervention.** The purpose of this disclosure is to refer _____ (print child's name) to the Illinois Early Intervention program. I, _____ (print name of parent or guardian), give my permission for my child's primary health care provider, _____ (print provider's name), to share pertinent information about my child, _____ (print child's name), regarding suspected developmental delay or related medical conditions with the Early Intervention program. I understand that I may withdraw this consent by written request to my child's primary health care provider, except to the extent it has already been acted upon.

2. **Release Early Intervention Eligibility Determination Information to Referral Source.** The purpose of this disclosure is to provide Early Intervention eligibility determination information, i.e., whether my child is eligible to receive Early Intervention services and what services they are, and other referrals provided by Early Intervention for _____ (print child's name) to:

- ☐ my child's primary health care provider listed in Section 4 (parent/guardian initial:____)
- ☐ the referral agency listed in Section 3 (parent/guardian initial:____).

I give my permission for the Early Intervention program to share reports and results related to the previously referenced information with my child's primary health care provider listed above. (parent/guardian initial:____). I understand that I may withdraw this consent by written request to Early Intervention, except to the extent it already has been acted upon.

I certify that this Authorization to Release Information has been given freely and voluntarily. Information collected hereunder may not be re-disclosed unless the person who consented to this disclosure specifically consents to such re-disclosure and or the re-disclosure is allowed by law. I understand I have a right to inspect and copy the information to be disclosed.

Parent/Legal Guardian Signature*_____ Date:_____/_____/_____

*Consent is effective for a period of 12 months from the date of your signature on this release.

Section 7. For CFC Office Use Only

Date Referral Received: _____/_____/_____ Name of person receiving referral: _____