



State of Hawai'i Department of Health
Early Intervention Section (EIS)

Oah'u: 808-594-0066
Toll Free: 800-235-5477
Fax: 808-586-0016

EARLY INTERVENTION (EI) REFERRAL FORM

***Required information for referral to be processed**

Call/Fax Date: _____
MM/DD/YY

Referral Source Name: _____ Fax #: _____ Ph #: _____

Relationship to Child: Parent Physician CWS Home Visiting DOH Home Visiting Early Head Start
 Preschool/Childcare Public Health Nursing DHS-CWS Other _____

Organization/Affiliation: _____

Address, include city & zip code (if not parent): _____

How Referral Source Became Aware of EI: Brochure Poster Child Fair/Event Table _____

***Child's Name:** _____ ***Date of Birth:** _____
First Last MM/DD/YY

Gender: M F Age: _____ years _____ months _____ weeks

***Legal Guardianship:** Parent(s) Other: _____ Phone: _____
 CWS: SW Name: _____ Phone: _____ Fax: _____

***Area(s) of Concern: (check all that apply)**

Developmental: Adaptive Cognitive Communication Fine Motor Gross Motor Social/Emotional

Medical: Chrom. Ab. Genetic/Congenital Disorder Other: _____
 Technology Dependent Skilled Nursing Needed: Amount of Hours per week: _____

Diagnosis: _____ ICD Code: _____

Developmental and/or Medical Concerns: _____

Screening/Assessments Done:

ASQ ASQ-SE PEDS M-CHAT Denver HELP Other: _____
 Newborn Hearing Screening Results: Left - Pass: Yes No Right - Pass: Yes No

Agencies Working w/ Child: Child Welfare Services Children w/ Special Health Needs Program Early Head Start
 CWS Home Visiting DOH Home Visiting Public Health Nursing Other: _____

***Primary Caregiver Name(s):** _____

***Relationship to Child:** mother father resource caregiver guardian other: _____

Primary Caregiver Name(s): _____

Relationship to Child: mother father resource caregiver guardian other: _____

***Child's Residence Address (include apt. #, city & zip code):** _____

***Legal Guardian's Mailing Address (include city & zip code), if different than child's residence:** _____

***Phone #** (h): _____ (c): _____ (c): _____ (w): _____
(primary) (secondary)

(other): _____ Best Call Time: _____ Preferred Call Number: _____

My signature below provides consent for the Department of Health Early Intervention to share the status of the referral with the referral source.

Legal Guardian Signature: _____ Date: _____

EI Referral Form

Instructions

NOTE: Use "TAB" key to move between fields - Do NOT use "ENTER" key

PURPOSE OF FORM

EI Referral Form is used by referral sources to submit a referral to Early Intervention when there is a concern about a child's development. The form is also used by the EI Referral Unit and EI Programs when a call in referral is received.

HOW TO COMPLETE THIS FORM

Call/Fax date: Enter the date call received or date form is faxed to EI Referral Line.

Referral Source Name: Enter the name of the person making the referral. NOTE: If someone is making the referral on another person's behalf (e.g., Nurse for Doctor), enter the person who requested initiating the referral (e.g., Doctor).

Fax #: Enter fax number of referral source, including area code if other than 808.

Ph #: Enter phone number of referral source, including area code if other than 808.

Relationship to Child: Select the most appropriate box. Other options is as follows: (write in if not listed)

DOE	Other Clinic	Other Public Health Provider
Domestic Violence Agency	Other Family Member	Other Social Service Provider
Domestic Violence Shelter	Other Healthcare Provider	Resource Caregiver (Foster Parent)
Homeless Family Shelter	Other Public Health Agency	

NOTE: DHS VCM & FSS, select "Other Social Service Provider" and indicate VCM of FSS after Program Name.

Organization/Affiliation: Enter the name of Organization/Affiliation (e.g. Name of Hospital, Name of Program, etc.)

Address, include city & zip code (if not parent): Enter Organization/Affiliation address

How Referral Source Became Aware of EI: If this is your first time referring to EI, please select the most appropriate box.

*Child's Name: Enter child's legal name (first and last name)

*Date of Birth: Enter child's date of birth

Gender: For boys, select "M" and for girls, select "F"

Age: Enter year, months, and weeks

*Legal Guardian: Select the most appropriate box. For "other" and "CWS," include the name of the guardian.

Phone: enter phone number of legal guardian

Phone/Fax: enter phone number and fax number of Child Welfare Services (CWS) Social Worker (SW)

*Areas(s) of Concern: Select all that apply

Diagnosis: Enter diagnosis, if known

ICD code: Enter ICD-9 or ICD-10 (effective 10/1/15) code

Developmental and/or Medical Concerns: write a brief description of any concerns

Screening/Assessment Done: Select any screenings/assessments completed. **NOTE: If known, please include results of the Newborn Hearing Screening.**

Agencies Working w/ Child: Select all that apply

*Primary Caregiver Name(s): Enter primary caregiver name(s)

Relationship to Child: Select the most appropriate box that best describes the primary caregiver's relationship to the child.

*Child's Residence Address (include city & zip code): Enter address of the primary caregiver.

*Legal Guardian's Mailing Address (include apt. #, city & zip code), if different than child's residence: Enter mailing address if different than residence address of the primary caregiver. NOTE: If homeless, include general vicinity/relative's address and contact number.

*Phone #: enter home (h), cell (c), work (w), and other number(s)

Best Call Time: Enter the best time to call the primary caregiver

Preferred Call Number: Enter the preferred phone number for the primary caregiver.

Signature of the Legal Guardian allows the EI Program to share the status of the referral with the referral source.

Date: Enter date signature was obtained.

***Required information for a referral to be considered a complete.**