ORLEANS COUNTY EARLY INTERVENTION / CHILD FIND REFERRAL FORM

14012 Route 31 West, Albion, NY 14411 (585-589-2761 or 589-2777; Fax 585-589-3169)

Referral Date: _____ 45 Day _____ County Referred to: Orleans☐ Other_____

Child's Name: _____

(Last) (First) (MI)

DOB: _____ County of Birth: _____ Sex: M ☐ F ☐

Address: _____

Home phone: _____ Alternative phone: _____

Child resides with: Mother ☐ Father ☐ Other _____

Mother's Name: _____ Father's Name: _____

Mother's DOB: _____ Father's DOB: _____

Other Active Adult: _____

Dominant Language Spoken at Home: English☐ Spanish☐ Other_____

Child's Primary Care Physician: _____

Referred by: _____ Agency: _____

Address: _____ Phone: _____

Is parent aware of referral: YES☐ NO☐ Fax: _____

☐ **Parent does not object to referral (Attestation)**

Race: White☐ Black☐ Native American☐ Asian☐ Hawaiian N Pacific Is☐

Ethnicity: Hispanic☐ Non-Hispanic☐

EARLY INTERVENTION REFERRAL: This child is being referred because (s)he is suspected of having a disability, which includes a developmental delay and/or a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

Confirmed Diagnosis:_____

INDICATE suspected area(s) of concern:

- Cognitive ☐
- Adaptive ☐
- Social/Emotional ☐
- Communication ☐
- Physical ☐
- (incl. vision/hearing)
- COMMENTS: _____

CHILD FIND REFERRAL (check all that apply)

☐Disengaged from primary care
☐Uninsured
☐Child is at-risk of developing a delay/disability

Information should be sent to:
Mother☐ Father☐

Other_____

COMMENTS:_____

EIO Designated ISC: ☐Landon ☐Fields

Date Assigned: _____

NYEIS Entry Date: _____