Clinton County Health Department
133 Margaret St., Plattsburgh, NY 12901 Phone: (518) 565-4848 FAX: (518) 565-4509

Early Intervention Referral Form

Public Health
Prevent. Promote. Protect.

Child's Name: _____ DOB: ____/____/____
Home Address: _____ Gender: ____M ____F
_____
Race: __White __ Asian __ African American __Native American __Hawaiian /Pacific Islander
Ethnicity: __Hispanic __Non-Hispanic
Parent(s) Name: _____
Phone: Home - (____)_____ Cell - (____)_____

Reason for Referral (Check only one)

____ **Early Intervention:** Child with a suspected or known developmental delay or disability

____ **Developmental Monitoring:** Child is typically developing but may be "at risk" for atypical development **or** child missed or failed Newborn Hearing Screening

Parent was consulted and **DOES NOT OBJECT / OBJECTS** to the referral **(CIRCLE ONE).**

Referred by: _____ Phone: _____

Address:_____

For the information shared below, the referral source attests to having written informed parental consent. _____ Yes _____ No

Area (s) of concern, diagnosis (if known): _____
_____
_____

Caregiver or alternate contact name: _____
Phone: ( ) _____
Relation to child: _____Parent ____ Grandparent _____ Foster Parent
_____ Other, Specify _____

Birth Hospital: _____ Location: _____
Birth Weight: Pounds _____ Ounces _____ or Grams _____
Gestational age ____weeks
Child's Primary Care Physician: _____

Office use only:

NYEIS date enter _____NYEIS # _____
CCHD person receiving the referral: _____
Referral is being assigned to: _____
For Early Intervention referrals "Day 1" is: _____
"DAY 45"is: _____