



Please complete this form for referring a child to Early Intervention (Part C) if you prefer to do so in writing. An auto eligibility diagnosis of a specific condition or disorder is not necessary for a referral. Children can also qualify for Early Intervention Services by demonstrating a 50% delay in 1 area or a 25% delay in 2 areas of development.

Child's Information

El Code #:	Referral Date:	Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child's Name:		Date of Birth:	Child's Age in Months:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Race/Ethnicity:		
Home Address:	City:	State:	Zip Code:
Is home address the same as mailing address? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, please enter mailing address:</i>			
Mailing Address:	City:	State:	Zip Code:

Primary Contact (Legal Guardian)

Name:	Relationship to Child:		
Primary Language:	Home Phone:	Other Phone:	
Email address:	Preferred Method of contact:		

Secondary Contact

Name:	Relationship to Child:		
Primary Language:	Home Phone:	Other Phone:	
Email address:			

Reason(s) for Referral to Nevada Early Intervention Services

Please check all that apply:

Identified condition or diagnosis (ex. Spina Bifida, PKU, etc.).

If checked, please enter condition:

Suspected developmental delay or concern (please check area of concern):

Motor/Physical Cognitive Social/Emotional Speech/Language Self Help Vision Hearing

Newborn Hearing Screen Referral: Passed Failed

Other Concerns? Yes No *If "Yes" please complete this section:*

If "Other concerns" is checked, please explain/describe:

Prematurity – Was the child born premature? Yes No *If "Yes" please complete this section:*

Gestation/Weeks:	Birth Weight: Lbs. Oz. / or Grams	Birth length: (inches)
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Was the child in the NICU? Yes No

If "Yes", please explain/describe:

How many days / weeks / months was the baby in the Hospital?

Were there any **complications while in the hospital** after the birth? Yes No

If "Yes", please explain/describe:

Other Concerns? Yes No *If "Yes" please complete this section:*

If "Other concerns" is checked, please explain/describe:



EI Code #

Child's Current Health Care

Pediatrician / Primary Health Care Provider: _____ Date of Last Appointment: _____

Pediatric Office / Practice Name: _____

Referral Source Contact Information:

Referring Agency/Individual: _____

Contact Name: _____ Date Received: _____

Address: _____

Referral Phone: _____ Referral Fax: _____ Referral Email: _____

To be completed by Referring Early Intervention Office

- APT TMG-N TMG-S CHHS-N CHHS-S Continuum MDDA PKEI
 NEIS South NEIS Carson City NEIS NE NEIS NW

Release of Information Consent:

I, _____ (Name of parent/guardian), give **verbal permission** for my pediatric health care provider and/or Early Intervention Services, _____ (Provider's name), to share any and all pertinent information regarding my child _____ (Child's name).

System Point of Entry Contact Information

<p>Northwest Region Referral Phone: (775) 688-1341 Referral Fax: (775) 688-2984 Reno Referral Email: adsd-neis-reno-fax@adsd.nv.gov</p>	<p>South Region Referral Phone: (702) 486-9200 Referral Fax: (702) 486-5735 Referral Email: NEISReferrals@adsd.nv.gov</p>
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<p>Carson City Region Referral Phone: (775) 687-0101 Referral Fax: (775) 687-0110 Referral Email: ccneis@adsd.nv.gov</p>	<p>Northeast Region Referral Phone: (775) 753-1214 Referral Fax: (775) 753-1347 Referral Email: NEISElko@adsd.nv.gov</p>
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To be completed by System Point of Entry Only:

Referral Specialist Name: _____

Eligibility: Medically Eligible Rotation Rural Location

Program Selection: APT TMG-N TMG-S CHHS-N CHHS-S Continuum MDDA PKEI
 NEIS South NEIS Carson City NEIS NE NEIS NW

Date: _____ Medical Records: Yes No

Referral Source: _____

Additional Notes: _____

This form was adapted by Nevada from a form created through a collaboration between the American Academy of Pediatrics and the Tracking, Referral and Assessment Center for Excellence, Orelena Hawks Puckett Institute, Inc. The development of this form was supported, in part, by funding from the US Department of Education, Office of Special Education Programs, Research to Practice Division. (H324G020002)