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 showing a 50% delay in 1 area or a 25% delay in 2 areas of development.

Legal Guardian/Child Contact Information:

Child's Name:			**Interpreter Needed:**	☐	Yes	☐	No
Date of Birth	**Child's Age** (Months):		**Gender:** ☐ **M** ☐ **F**		**Race:**		
Home Address:							
Legal Guardian Name:			**Relationship to Child:**				
Primary Language:	**Home Phone:**		**Other Phone:**				
Legal Guardian Name:			**Relationship to Child:**				
Primary Language:	**Home Phone:**		**Other Phone:**				

Reason(s) for Referral to Nevada Early Intervention Services – Please check all that apply

☐ **Identified condition or diagnosis (ex. Spina Bifida, PKU, etc.):**							
☐ **Suspected developmental delay or concern (please check areas of concern):**	☐ Motor/Physical	☐ Cognitive	☐ Social/Emotional				
	☐ Speech/Language	☐ Behavior	☐ Vision	☐ Hearing			
☐ **Newborn Hearing Screen Referral:**	☐ Passed	☐ Failed					
Prematurity:	☐ No	☐ Yes – if "Yes": Gestation/Weeks:					
Was the child in the ***NICU***?	☐ No	☐ Yes – if "Yes": Reason:					
	How many days / weeks / months was the baby in the Hospital?						
Birth Weight:		***Birth Length:***					
Were there any ***problems while in the hospital*** after the birth?	☐ No	☐ Yes – if "Yes", please explain/describe below:					
Explain / Describe:							

☐	**Other Concerns / Notes**

Child's Current Health Care		
Pediatrician / ***Primary Health Care Provider***	Pediatrician's Name:	Pediatric Office / Consortium's Name:
Date of Last Appointment:		

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	**Office Receiving Referral:**
	☐ **APT** ☐ **TMG-N** ☐ **CHHS-N** ☐ **NEIS Carson City** ☐ **NEIS Elko** ☐ **NEIS NW** ☐ **TMG-S** ☐ **CHHS-S** ☐ **Continuum** ☐ **MDDA** ☐ **PKEI** ☐ **NEIS South**

Release of Information Consent:

I, *(Name of parent/guardian)*, give **verbal permission** for

☐ my pediatric health care provider *(provider's name)* and/or

☐ early intervention services *(provider's name)*

to share any and all pertinent information regarding my child *(Child's name)* .

Parent/Guardian Signature: **Date:**

System Point of Entry Contact Information	
North Region Referral Phone: 775-688-1341 **North Region Referral Fax**: 775-688-2984 **North Region Referral Email:** NEISRenoFront@adsd.nv.gov NEISCarsonCity@adsd.nv.gov *or* NEISElko@adsd.nv.gov	**South Region Referral Phone:** 702-486-9200 **South Region Referral Fax:**702-486-5735 **South Region Referral Email:** NEISReferrals@adsd.nv.gov

To be completed by System Point of Entry Only:			
Family Specialist Name:	☐ Program Selection: ☐ Medically Fragile: ☐ Rotation: ☐ Rural Location:	**EI Program Selection:** ☐ **APT** ☐ **TMG-N** ☐ **TMG-S** ☐ **CHHS-N** ☐ **CHHS-S** ☐ **Continuum** ☐ **MDDA** ☐ **PKEI** ☐ **NEIS South** ☐ **NEIS Carson City** ☐ **NEIS Elko** ☐ **NEIS NW**	
EI Code #:	**Date:**	**Medical Records:**	☐ Yes ☐ No
Referral Source:		**Additional Notes:**	

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