State of Illinois
Department of Healthcare and Family Services

Standardized Illinois Early Intervention Referral Form

Please complete Sections 1 through 6 of this form to refer a child to Early Intervention (EI) for eligibility determination.

Section 1. Child Contact Information

Child Name: _____ If the child is known by another name enter it here: _____

Date of Birth: _____ Child Age: _____ Gender: Male ☐ Female ☐ Race: _____

Address: _____

City: _____ State _____ Zip Code _____ County _____

Type of Insurance Coverage: Medicaid ☐

Parent/Guardian Name: _____ Relationship to Child: _____

Primary Language: _____ Home Phone _____ Other Phone _____

Alternate or Emergency Contact Person: _____ Phone Number _____

Section 2. Reason(s) for Referral

Reason(s) for referral to EI (Please check all that apply):

☐ Identified condition or medical diagnosis (e.g., Spina Bifida, Down Syndrome): _____

☐ Suspected developmental delay based on objective developmental screening using (please note screening tool used) _____ (Please check area[s] of concern): ☐ Motor/Physical ☐ Social/Emotional ☐ Cognitive ☐ Speech ☐ Behavior ☐ Adaptive/Self-help Skills ☐ Language/Communication ☐ Vision/Hearing

☐ Other, specify _____

Comments: _____

☐ Environmental Factors ("at risk") (Please describe environmental risk factors): _____

☐ Other, (Please describe): _____

☐ Family is aware of reason for referral

Section 3. Referral Source Contact Information

If the Primary Care Provider is the source of referral, skip Section 3, go to Section 4 and check here ☐

Referral Date: _____

Name of Agency Making Referral: _____

Address: _____

City _____ State _____ Zip Code _____

Office Phone _____ Office Fax _____

E-mail _____ Contact Person at Referral Site: _____

Section 4. Primary Care Provider Contact Information

Referral Date: _____

Name of Child's Primary Care Provider: _____

Street Address: _____

City _____ State _____ Zip Code _____

Office Phone _____ Office Fax _____

E-mail _____ Contact Person at Primary Care Provider Office: _____

Child and Family Connection (CFC) Office, please send the following items:

- Date the family was contacted and outcome of the contact
- Eligibility for services and a list of services the child is eligible for
- A summary of the Individualized Service Plan (IFSP)
- Other referrals provided by EI to the child/family

Section 5. Early Intervention CFC Office Referral Location

Insert the CFC number where the child is being referred: CFC #: _____

CFC Offices can be located using the DHS Office Locator available online at: http://www.dhs.state.il.us/page.aspx?module=12

Section 6. Authorization to Release Information

1. **Referral to Early Intervention.**

The purpose of this disclosure is to refer (print child's name) _____ to the Illinois Early Intervention program.

I, (print name of parent or guardian), _____

give my permission for my child's primary care provider, (print provider's name) _____

to share pertinent information about my child, (print child's name) _____

regarding suspected developmental delay or related medical conditions with the Early Intervention program. I understand that I may withdraw this consent by written request to my child's primary care provider, except to the extent it has already been acted upon.

2. **Release Early Intervention Eligibility Determination and Service Information to Referral Source.** The purpose of this disclosure is to release information from the Department of Human Services (DHS) to the Department of Healthcare and Family Services (HFS) about your child, including name, AllKids recipient identification number, date of birth, and information about your child's referral to and eligibility for Early Intervention, including services received and other referrals made by Early Intervention. Your consent allows HFS to share information with your child's assigned primary care provider (listed in Section 4 above) and treating doctors within the group, for care coordination. Care coordination allows your child's primary care provider to be notified of your child's Early Intervention assessment, eligibility for services and services received. Your consent allows HFS to use the information for analysis purposes and to measure the quality of the care coordination process between the primary care provider and Early Intervention. Information and reports resulting from data analysis will not be released with any individually identifying information about your child.

Your consent allows the Early Intervention program to share reports and results related to the previously referenced information with your child's primary care provider listed above in Section 4. Your consent allows the Early Intervention program to share reports and results related to previously referenced information with the referral agency listed above in Section 3, if any.

I understand that I may withdraw this consent by written request to Early Intervention, except to the extent it already has been acted upon. I certify that this Authorization to Release Information has been given freely and voluntarily. Information collected hereunder may not be re-disclosed unless the person who consented to this disclosure specifically consents to such re-disclosure and or the re-disclosure is allowed by law. I understand I have a right to inspect and copy the information to be disclosed.

Parent/Legal Guardian Signature* _____ Date _____

*Consent is effective for a period of 12 months from the date of your signature on this release.

Section 7. For CFC Office Use Only

Date Referral Received: _____ Name of person receiving referral: _____