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**

EI Code #: | Referral Date: | Interpreter Needed: ☐ Yes ☐ No

Child's Name: | Date of Birth: | Child's Age in Months:

Gender: ☐ M ☐ F | Race/Ethnicity: Select from List

Home Address: | City: | State: | Zip Code:

Is home address the same as mailing address? ☐ Yes ☐ No *If no, please enter mailing address:*

Mailing Address: | City: | State: | Zip Code

**Primary Contact (Legal Guardian)**

Name: | Relationship to Child: Select From List

Primary Language: | Home Phone: | Other Phone:

Email address: | Preferred Method of contact: Select From List

**Secondary Contact**

Name: | Relationship to Child: Select From List

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)

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**

**Northwest Region**
**Referral Phone**: (775) 688-1341
**Referral Fax**: (775) 688-2984
**Reno Referral Email:** adsd-neis-reno-fax@adsd.nv.gov

**South Region**
**Referral Phone:** (702) 486-9200
**Referral Fax:** (702) 486-5735
**Referral Email:** NEISReferrals@adsd.nv.gov

**Carson City Region**
**Referral Phone**: (775) 687-0101
**Referral Fax**: (775) 687-0110
**Referral Email:** ccneis@adsd.nv.gov

**Northeast Region**
**Referral Phone:** (775) 753-1214
**Referral Fax:** (775) 753-1347
**Referral Email:** NEISElko@adsd.nv.gov

**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: Select from List

Additional Notes:

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