Rhode Island Early Intervention Statewide Referral and Demographics

Referral Date: | Program Name: | Discussed Referral Process w/ Family ☐ Yes ☐ No

Client ID#: | Family's Preferred Program: | ☐ No Preference

Child:_____ AKA:_____
Last. First Middle Initial

DOB:____/____/____ Gender ☐M ☐ F ☐ Other SSN: _____ Home Language: _____

_____ _____ ____ _____ _____
Street Address and Apt.#. City State Zip Code Home Phone

Referred By:

- ☐ Parent/Guardian*
- ☐ CEDARR
- ☐ Child Care Provider
- ☐ DCYF (175)
- ☐ FCCP
- ☐ EI Transfer (RI)
- ☐ Early Head Start/Head Start
- ☐ Inpatient Hospital (not pre/postnatal)
- ☐ NICU/PICU
- ☐ Lead Program
- ☐ Mental Health Center
- ☐ Outpatient Hospital Based Prog.
- ☐ Community Specialty Office
- ☐ Pediatrician/Family Practice
- ☐ RIHAP
- ☐ VNA/VNS (except First Connections)
- ☐ First Connections
- ☐ WIC
- ☐ Out of State Referral
- ☐ Other

* **If referred by Parent/Guardian, also check how they heard about EI**

Have you had previous involvement with Early Intervention? ☐ Yes ☐ No ☐ Second Episode ☐ Another Child

Referral Reason:

_____
_____
_____
Current Diagnosis: _____

Referral Source Contact Information:

Name:_____Tel:_____
Address: _____
_____
Address Same as Child? ☐Yes ☐No Relationship:_____

Family Primary:

Parent/Guardian: _____
☐Mother ☐Father ☐Legal Guardian ☐Foster Parent ☐Grandparent

SSN:_____ DOB:_____
Address: _____
_____
Home Tel:_____Work Tel:_____
Mobile:_____Email:_____
Marital Status: ☐Married ☐Divorced ☐Separated ☐Single ☐Widowed
UnknownLanguage Spoken:_____Translator? ☐Yes ■ No
Education:_____ Employment Type: ☐FT ☐PT ☐UE ☐Disabled ☐Ret.
Employer:_____Tel:_____
Address:_____

Parent/Guardian: _____
☐Mother ☐Father ☐Legal Guardian ☐Foster Parent ☐Grandparent

SSN:_____ DOB:_____
Address: _____
_____
Home Tel:_____Work Tel:_____
Mobile:_____Email:_____
Marital Status: ☐Married ☐Divorced ☐Separated ☐Single ☐Widowed
UnknownLanguage Spoken:_____Translator? ☐Yes ■ No
Education:_____ Employment Type: ☐FT ☐PT ☐UE ☐Disabled ☐Ret.
Employer:_____Tel:_____
Address:_____

Contacts:

Name: _____
☐Grandparent ☐ Social Worker ☐Other:_____
Address: _____
Tel:_____Fax:_____

Name: _____
☐Grandparent ☐ Social Worker ☐Other:_____
Address: _____
Tel:_____Fax:_____

Race/Origin:

Is child Hispanic/Latino?
☐Yes ☐No

Is the child?
☐American Indian orAlaska Native
☐Asian
☐Black or African American
☐Hawaiian/Pacific Islander
☐White

You may check more than one

Place of Residence:
☐Mother's Home
☐Both Parents
☐Father's Home
☐Foster Home
☐Group Home
☐Other
☐Relative
☐Shelter

Primary Medical:

Physician's Name: _____
Address: _____
_____
Tel:_____Fax:_____

Place of Birth:_____, _____
State Country

Health Insurance Information: ☐ Private ☐ RIte Care ☐ Other Medicaid ☐ Uninsured

Primary Plan:_____ID#_____

Policyholder's Name: _____

Health Insurance Information: ☐Private ☐RIte Care ☐Other Medicaid ☐ Uninsured

Secondary Plan:_____ID#. Policyholder's Name: _____

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