

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: _____	<input type="checkbox"/> No Preference		
Child: _____ Last. First Middle Initial		AKA: _____		
DOB: ____/____/____ Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other SSN: _____		Home Language: _____		
Street Address and Apt.#: _____		City: _____	State: _____	Zip Code: _____
Home Phone: _____				
Referred By:				
<input type="checkbox"/> Parent/Guardian*	<input type="checkbox"/> Early Head Start/Head Start	<input type="checkbox"/> Mental Health Center	<input type="checkbox"/> VNA/VNS (except First Connections)	
<input type="checkbox"/> CEDARR	<input type="checkbox"/> Inpatient Hospital (not pre/postnatal)	<input type="checkbox"/> Outpatient Hospital Based Prog.	<input type="checkbox"/> First Connections	
<input type="checkbox"/> Child Care Provider	<input type="checkbox"/> NICU/PICU	<input type="checkbox"/> Community Specialty Office	<input type="checkbox"/> WIC	
<input type="checkbox"/> DCYF (175)	<input type="checkbox"/> Lead Program	<input type="checkbox"/> Pediatrician/Family Practice	<input type="checkbox"/> Out of State Referral	
<input type="checkbox"/> FCCP		<input type="checkbox"/> RIHAP	<input type="checkbox"/> Other	
<input type="checkbox"/> EI Transfer (RI)				
* If referred by Parent/Guardian, also check how they heard about EI				
Have you had previous involvement with Early Intervention? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Second Episode <input type="checkbox"/> Another Child				
Referral Reason:		Referral Source Contact Information:		
_____		Name: _____ Tel: _____		
_____		Address: _____		
_____		_____		
Current Diagnosis: _____		Address Same as Child? <input type="checkbox"/> Yes <input type="checkbox"/> No Relationship: _____		
Family Primary:				
Parent/Guardian: _____		Parent/Guardian: _____		
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/> Grandparent		<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/> Grandparent		
SSN: _____ DOB: _____		SSN: _____ DOB: _____		
Address: _____		Address: _____		
_____		_____		
Home Tel: _____ Work Tel: _____		Home Tel: _____ Work Tel: _____		
Mobile: _____ Email: _____		Mobile: _____ Email: _____		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed		
Unknown Language Spoken: _____ Translator? <input type="checkbox"/> Yes <input type="checkbox"/> No		Unknown Language Spoken: _____ Translator? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Education: _____ Employment Type: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> UE <input type="checkbox"/> Disabled <input type="checkbox"/> Ret.		Education: _____ Employment Type: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> UE <input type="checkbox"/> Disabled <input type="checkbox"/> Ret.		
Employer: _____ Tel: _____		Employer: _____ Tel: _____		
Address: _____		Address: _____		
Contacts:				
Name: _____		Name: _____		
<input type="checkbox"/> Grandparent <input type="checkbox"/> Social Worker <input type="checkbox"/> Other: _____		<input type="checkbox"/> Grandparent <input type="checkbox"/> Social Worker <input type="checkbox"/> Other: _____		
Address: _____		Address: _____		
Tel: _____ Fax: _____		Tel: _____ Fax: _____		
Race/Origin:		Place of Residence:		Primary Medical:
Is child Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Mother's Home		Physician's Name: _____
Is the child? <input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> Both Parents		Address: _____
<input type="checkbox"/> Asian		<input type="checkbox"/> Father's Home		_____
<input type="checkbox"/> Black or African American		<input type="checkbox"/> Foster Home		Tel: _____ Fax: _____
<input type="checkbox"/> Hawaiian/Pacific Islander		<input type="checkbox"/> Group Home		
<input type="checkbox"/> White		<input type="checkbox"/> Other		
You may check more than one		<input type="checkbox"/> Relative		Place of Birth: _____
		<input type="checkbox"/> Shelter		State Country
Health Insurance Information: <input type="checkbox"/> Private <input type="checkbox"/> RIte Care <input type="checkbox"/> Other Medicaid <input type="checkbox"/> Uninsured				
Primary Plan: _____ ID# _____				
Policyholder's Name: _____				
Health Insurance Information: <input type="checkbox"/> Private <input type="checkbox"/> RIte Care <input type="checkbox"/> Other Medicaid <input type="checkbox"/> Uninsured				
Secondary Plan: _____ ID# Policyholder's Name: _____				
