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 ☐ Private Insurance ☐ None ☐

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): Date referral made: _____

☐ Identified physical or mental condition (List of Medical Diagnoses or type URL http://www.dhs.state.il.us/page.aspx?item=82917).

If yes, please describe: _____

☐ Suspected developmental delay based on objective screening (please name tool(s)): _____

Check area[s] of concern: ☐ Motor/Physical ☐ Social/Emotional ☐ Cognitive ☐ Speech ☐ Behavior ☐ Vision/Hearing ☐ Language/Communication ☐ Adaptive/Self-help Skills

Comments: _____

☐ At risk conditions (e.g., diagnosed caregiver condition, other risk factors to child) (List of At Risk Conditions or type URL http://www.dhs.state.il.us/page.aspx?item=96963), please describe: _____

☐ Other, (Please describe): _____

☐ Family is aware of reason for referral

Section 3. Referral Source Contact Information

If the child's Health Care Provider is making the referral, skip Section 3 and complete Section 4. If an Early Childhood Program is making the referral, check here. NOTE: Any agency may use this referral form. ☐

Name of Agency Making Referral: _____

Address: _____

City _____ State _____ Zip Code _____

Office Phone _____ Office Fax _____

E-mail _____ Contact Person at Referral Site: _____

Section 4. Health Care Provider Contact Information

Agencies listed in Sec. 3, please complete Sec. 4 (with parental consent) to assure child's Health Care Provider is informed of referral.

Name of Child's Health Care Provider: _____

Street Address: _____

City _____ State _____ Zip Code _____

Office Phone _____ Office Fax _____

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

Section 5. Early Intervention CFC Office Referral Location

FAX form to the CFC where the child is being referred: CFC #: _____

If CFC is unknown, use child's county/ZIP code, locate CFC office using the DHS Office Locator at: http://www.dhs.state.il.us/page.aspx?module=12

Section 6. Authorization to Release Information

1. Consent for **Referral to Early Intervention** and for Release of Health Information to Early Intervention Program

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 health care provider, (listed in Section 4 above) 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 health care provider, except to the extent it has already been acted upon.

2. Consent to **Release Early Intervention Reports and Results to Healthcare Provider and/or Other Referring Agency.** Your consent allows the Early Intervention program to share reports and results, as listed in the EI Fax Back Form, with your child's health care provider listed in Section 4, or the referral entity. The CFC will send the HFS 652 Illinois Early Intervention Program Referral Fax Back form with the appropriate information: https://www.illinois.gov/hfs/SiteCollectionDocuments/hfs652.pdf

3. Consent to **Release Early Intervention Eligibility Determination and Service Information to Illinois Department of Healthcare and Family Services.** For children enrolled in All Kids, your consent allows the release of information from 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 health care provider (listed in Section 4 above, if any) and treating doctors within the group, and managed care organization (MCO), if applicable, for care coordination. Care coordination allows your child's health care provider to be notified with results of your child's Early Intervention evaluation and/or 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 health care provider and Early Intervention. Information and reports resulting from data analysis will not be released with any individually identifying information about your child.

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: _____