State of Hawai'i Department of Health
Early Intervention Section (EIS)

Oah'u: 808-594-0066
Toll Free: 800-235-5477
Fax: 808-594-0073

EARLY INTERVENTION (EI) REFERRAL FORM

*Required information for referral to be processed

Call/Fax Date: _____ MM/DD/YY

Referral Source Name: _____ Fax #: _____ Ph #: _____

Relationship to Child: ☐ Parent ☐ Physician ☐ CWS Home Visiting ☐ DOH Home Visiting ☐ Early Head Start
☐ Preschool/Childcare ☐ Public Health Nursing ☐ DHS-CWS ☐ Other _____

Organization/Affiliation: _____

Address, include city & zip code (if not parent): _____

How Referral Source Became Aware of EI: ☐ Brochure ☐ Poster ☐ Child Fair/Event Table ☐ _____

*Child's Name: _____ First _____ Last *Date of Birth: _____ MM/DD/YY

Gender: ☐ M ☐ F Age: _____ years _____ months _____ weeks

*Legal Guardianship: ☐ Parent(s) ☐ Other: _____ Phone: _____
☐ CWS: SW Name: _____ Phone: _____ Fax: _____

*Area(s) of Concern: (check all that apply)

Developmental: ☐ Adaptive ☐ Cognitive ☐ Communication ☐ Fine Motor ☐ Gross Motor ☐ Social/Emotional

Medical: ☐ Chrom. Ab. ☐ Genetic/Congenital Disorder ☐ Other: _____
☐ Technology Dependent ☐ Skilled Nursing Needed: Amount of Hours per week: _____

Diagnosis: _____ ICD Code: _____

Developmental and/or Medical Concerns: _____

Screening/Assessments Done:

☐ ASQ ☐ ASQ-SE ☐ PEDS ☐ M-CHAT ☐ Denver ☐ HELP ☐ Other: _____

☐ Newborn Hearing Screening Results: Left – Pass: ☐ Yes ☐ No Right – Pass: ☐ Yes ☐ No

Agencies Working w/ Child: ☐ Child Welfare Services ☐ Children w/ Special Health Needs Program ☐ Early Head Start
☐ CWS Home Visiting ☐ DOH Home Visiting ☐ Public Health Nursing ☐ Other: _____

*Primary Caregiver Name(s): _____

*Relationship to Child: ☐ mother ☐ father ☐ resource caregiver ☐ guardian ☐ other: _____

Primary Caregiver Name(s): _____

Relationship to Child: ☐ mother ☐ father ☐ resource caregiver ☐ guardian ☐ other:

*Child's Residence Address (include apt. #, city & zip code): _____

*Legal Guardian's Mailing Address (include city & zip code), if different than child's residence: _____

*Phone # (h): _____ (c): _____ (primary) (c): _____ (secondary) (w): _____

(other): _____ Best Call Time: _____ Preferred Call Number: _____

My signature below provides consent for the Department of Health Early Intervention to share the status of the referral with the referral source.

Legal Guardian Signature: _____ Date: _____