



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: _____