Service Coordination Agency
Early Intervention Referral Form (EI8045)

Department of Children & Youth
Help Me Grow Early Intervention

REFERRAL TYPE

☐ New referral: _____ (county) ☐ Re-referral: ETID # _____

☐ Transfer: ETID # _____ from _____ (county) to _____ (county)

REFERRER INFORMATION

Referrer agency name: _____

Referrer name: _____

Referrer role: ☐ SC agency ☐ PSP agency ☐ ODH - Confirmed Hearing Loss
(Note: If checked, diagnosis is confirmed.)

Referrer contact information (provide at least one)

Phone number: _____ Fax number: _____

Email address: _____

Address: _____

CHILD AND CAREGIVER INFORMATION

Child name: _____

Child date of birth: _____

Parent/Caregiver name: _____

Parent/Caregiver relationship to child: _____

Parent/Caregiver Contact Information (provide at least one) *Note: If transferring to another county, please list the new address if available.*

Address: _____

Phone number: _____ Email address: _____

Referral reason/notes:

As the referrer, I have spoken to the above named parent/caregiver and confirm that the parent/caregiver has a concern about the child's development and would like to proceed with an Early Intervention program referral.

_____ _____

Printed name Date

Please submit this referral to hmgreferrals@helpmegrow.org or fax to (855) 418-3322.