State of Hawaii
Department of Health
Early Intervention (EI) – H-KISS

For H-KISS Use Only:
Part C Referral:
☐ Yes ☐ No

EARLY INTERVENTION REFERRAL FORM

***Required Referral Information**

Call/Fax Date: _____ MM/DD/YY

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

Relationship to Child: ☐ **Parent** ☐ **Primary Care Physician** ☐ **EHS** ☐ **PHN** ☐ **Other:** _____

Organization/Affiliation: _____

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

How Referral Source Became Aware of EI: _____

***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-9 Code:** _____

Developmental, Medical, and/or Environmental Concerns: _____

Screening/Assessments Done:

☐ ASQ ☐ ASQ-SE ☐ M-CHAT ☐ DIAL-R ☐ Denver ☐ HELP ☐ PEDS

☐ Audiological (Include Newborn Hearing Screening) ☐ Other: _____

Agencies Working w/ Child: ☐ Child Welfare Services ☐ Children w/ Special Health Needs Program ☐ Early Head Start

☐ Enhanced Healthy Start ☐ Home Visiting ☐ Public Health Nursing ☐ Other: _____

***Primary Caregiver Name(s):** _____

Relationship to Child: ☐ mother ☐ father ☐ foster parent ☐ guardian ☐ other: _____

***Residence Address (include city & zip code):** _____

Mailing/Other Address (include city & zip code): _____

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

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

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

Legal Guardian Signature: _____ **Date:** _____

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