



Help Me Grow - Long Island Referral Form
(for Families with Children Prenatal-Age 5 in Nassau and Suffolk Counties)

Has the family agreed to this referral? Yes No Parent Signature _____

<u>Referring Provider Information (Person Who Should Receive Follow-Up)</u>			
Referral Date	Referral Site Name	Referring Provider Name	Title
Address		Unit	City
Zip Code			
Best Phone Number For Follow-Up	Fax Number*	Email	

Has a developmental screen ever been given? Yes No
 If yes: Screen and results/score: _____

Did you refer child/family to (check all that apply)?

Early Intervention (Date Submitted: _____) Mental Health Services (Date Submitted: _____)

Pre-school Special education (Date Submitted: _____) Other: _____ (Date Submitted: _____)

<u>Child's Information (AGE 5 OR UNDER) - put "n/a" if prenatal</u>			
Child's Last Name	Child's First Name	DOB (5 OR UNDER)	Gender <input type="checkbox"/> F <input type="checkbox"/> M
Address		Unit	City
Zip Code			

<u>Caregiver's Information</u>			
Parent/Caregiver Last Name	Parent/Caregiver First Name	Relationship to Child	Language(s) Spoken
Best Phone (check one) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		Other Phone (check one) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	
Email: _____			
Best time to contact <input type="checkbox"/> Morning (9AM-12PM) <input type="checkbox"/> Afternoon (12PM-5PM) <input type="checkbox"/> Evening (5PM-7PM)			

<u>Reason for Referral (Check Off All that Apply)</u>		
<input type="checkbox"/> Basic needs	<input type="checkbox"/> Developmental concern	<input type="checkbox"/> Legal assistance
<input type="checkbox"/> Behavior/social interactions	<input type="checkbox"/> Developmental screening	<input type="checkbox"/> Mental health (<input type="checkbox"/> parent <input type="checkbox"/> child)
<input type="checkbox"/> Cognitive/learning difficulty	<input type="checkbox"/> Fine motor/Gross motor	<input type="checkbox"/> Service/referral Navigation
<input type="checkbox"/> Child care/early child education	<input type="checkbox"/> General HMG information	<input type="checkbox"/> Other _____
<input type="checkbox"/> Communication	<input type="checkbox"/> Parent support	

Comments: _____

**HMG-LI will confirm when the fax was received; please contact us if you have not heard within 2 business days. HMG-LI will contact you once referrals were made and continually until the case is considered closed. Please call or email for updates prior to then as needed.*