earlySteps

EarlySteps Referral Form

SPOE USE ONLY

Date Received: _____ Date Intake Coordinator Assigned: _____

Date Entered: _____ Date Acknowledgement Sent: _____

Providers who serve infants/toddlers from birth to age three are required by state and federal regulations to make referrals to the lead agency for early intervention services. Referrals should be made within two working days of determining that an infant/toddler is possibly in need of early intervention services due to a developmental delay or a disability that is likely to result in a developmental delay if early intervention services are not provided.

Child's Name: _____ ____ _____ **Date of Birth:** ____/____/___
First MI Last

Medicaid #: _____ **Social Security #:** _____

Sex: ___Male ___Female

Race (Check *one* item, based on the family's self-report.): __ Hispanic/Latino of any race *OR* Non-Hispanic: ___White ___Black/African American __Asian ___Native Hawaiian/Pac Islander __American Indian/Alaska Native __2 or more races

Parent(s)/Guardian(s): _____

Address: _____ **Mailing Address:** _____

City: _____ **Zip:** _____ **Parish:** _____

Phones: (____)_____ (____)_____ (____)_____ **email:**_____

Alternate Contact Name: _____ **Relationship to Child:**_____ **Phone:** _____

Referred by: _____ **Phone:** (____)_____ **Fax:** (____)_____

Agency: _____ **Role:** _____ **Address:** _____

Physicians: please assign appropriate diagnostic code with referral information and sign: _____

****Please attach completed EarlySteps Health Summary form**

Reason for Referral

☐ **Suspected Developmental Delay**
- ☐ Cognitive
- ☐ Social/Emotional
- ☐ Adaptive
- ☐ Motor __Fine __Gross
- ☐ Language __Receptive __Expressive

ICD-9 Code: _____
Source of Screening Tool:
_____

☐ **Orthopedic Impairment**
ICD-9 Code: _____
_____

☐ **Sensory Impairment ICD-9 Code:**_____
- ☐ Hearing (Describe)
- ☐ Vision (Describe)

☐ **Autism ICD-9 Code:**_____
☐ **Traumatic Brain Injury ICD-9 Code:**___
☐ **Seizure Disorder ICD-9 Code:**_____

☐ **Genetic Disorder**
- ☐ Spina Bifida/Neural Tube Defect _____
- ☐ Down Syndrome _____
- ☐ Hydrocephaly _____
- ☐ Microcephaly _____
- ☐ Cleft Lip/Palate _____
- ☐ Stroke due to Sickle Cell Anemia _____
- ☐ Metabolic Disorder:_____

ICD-9 Code: _____

☐ **Congenital/Neonatal Disorder**
- ☐ Bacterial meningitis _____
- ☐ Cytomegalovirus (CMV) _____
- ☐ Herpes _____
- ☐ Rubella _____
- ☐ Syphilis _____
- ☐ Toxoplasmosis _____

ICD9-Code: _____

☐ **Neuromuscular Disorder**
- ☐ Cerebral Palsy _____
- ☐ Muscular Dystrophy _____

ICD-9 Code: _____

☐ **Birth History ICD-9 Code:**_____
- ☐ gestation = _____ weeks
- ☐ Low birth weight _____ grams
- ☐ Respiratory distress _____
- ☐ Ventilator support _____
- ☐ Intraventricular hemorrhage _____
- ☐ Birth asphyxia _____
- ☐ **NICU Treatment** _____
  - ☐ hospital stay = _____ days
  - Oxygen used __yes or __no

Exposure to Toxic Substances
- ☐ Drugs
- ☐ Alcohol
- ☐ Elevated Blood Lead level requiring chelation: ug/dl_____/_____

ICD-9 Code:_____

Other/Explanation: _____
_____
_____
_____
_____

How did you find out about EarlySteps? _____

Please Mail or Fax to: Fax: Address: