EarlySteps Referral Form

SPOE USE ONLY		
RECEIVED & ENTERED:	ASSIGNED INTAKE COORDINATOR: -	SERIAL NUMBER:
RECEIVED & ENTERED BY:	REFERRAL DETAILS: -	
ACKNOWLEDGEMENT SENT:	RELATED SERIAL NUMBER:	45TH DAY:

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 **7 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: _____ **Sex:** ◯ Male ◯ Female
FIRST MI LAST

Date of Birth: _____ **Medicaid Number:** _____ **SSN:** _____
MM/DD/YYYY

Race: ◯White ◯Black/African American ◯Asian ◯Native Hawaiian/ Other Pacific Islander ◯American Indian/Alaska Native ◯Hispanic/Latino ◯ 2 or More Races

Parent(s)/Guardian(s): _____

Address: _____ **Mailing Address:** _____

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

Phones: _____ _____ _____ **Email:** _____
HOME WORK CELL

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

Referred by: _____ **Phone:** _____ **Fax:** _____

Agency: _____ **Address:** _____

Role: _____ **Email:** _____ **Date of Referral:** _____

How did you learn of EarlySteps? _____

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-10 Code _____
Source of Screening Tool: _____

☐ **Orthopedic Impairment**
ICD-10 Code _____

☐ **Autism**
ICD-10 Code _____

☐ **Traumatic Brain Injury**
ICD-10 Code _____

☐ **Seizure Disorder**
ICD-10 Code _____

☐ **Sensory Impairment**
ICD-10 Code _____
- ☐ Hearing (Describe Below)
- ☐ Vision (Describe Below)

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

ICD-10 Code _____

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

ICD-10 Code _____

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

ICD-10 Code _____

☐ **Birth History**
ICD-10 Code _____
- ☐ Low birth weight_____grams
- ☐ Respiratory distress
- ☐ Ventilator support
- ☐ Intraventricular Hemorrhage
- ☐ Birth Asphyxia
- ☐ **NICU Treatment**
  - Hospital stay: ____ days
  - Gestation: ____ weeks

☐ **Exposure to Toxic Substances**
- ☐ Drugs
- ☐ Alcohol
- ☐ Elevated Blood Lead Level Requiring Chelation:
  UG/DL ____ / ____

ICD-10 Code _____

☐ **Other/Explanation:**

Please send via mail, email, or fax to First Steps Referral and Consulting
Fax: 337.359.8747 **Phone:** 337.359.8748 **Toll Free:** 1.888.307.0677
Address: 138 East Main Street New Iberia, Louisiana 70560
Email: referral@firststeps3.com **Website:** www.firststeps3.com

RESET

SERIAL NUMBER:

◉ Initial Health Summary
○ Health Summary Update

Health Summary

earlysteps
louisiana's early intervention system

This health information is necessary for eligibility determination and service planning for children who may be eligible for EarlySteps. Please complete this form as this child's primary medical provider. If you have questions, please contact the Intake Coordinator named on the cover letter. You may send this information with your referral. Your signature below indicates the accuracy of the information provided. *Thank you*!

Child's Name: _____ Date of Birth: _____ Parent/Guardian Name: _____

MEDICAL INFORMATION (Information needed for Initial Health Summary Only)

Reason(s) for Referral (if you referred this patient): _____

Birth Weight: _____ (grams) _____ (lbs/oz) Gestational Age: _____ Length of Hospital Stay: _____

Major complications, procedures: _____

Subsequent Hospitalizations/Surgeries: _____

CURRENT HEALTH STATUS (*Indicates data entered and stored electronically at the System Point of Entry)

Present concerns/diagnoses*/illnesses (**Please indicate ICD-10 codes next to diagnoses**.) Some children will be eligible for EarlySteps due to a medical diagnosis alone.

_____

ICD-10 Code: _____ Concerns:

_____

Current Medications: _____

Medical Precautions/allergies: _____

Immunizations are up to date: ○ YES ○ NO Date you last saw this child: _____

Vision: I (check one) ☐ have concerns ☐ do not have concerns about this child's vision. Has this child been referred to an ophthalmologist? ○ YES ○ NO If yes, please explain:

_____

Hearing: I (check one) ☐ have concerns ☐ do not have concerns about this child's hearing. Newborn Hearing Screening Results: ○ Passed ○ Further testing Needed

Date re-screened: _____ Results: _____ Was diagnostic testing completed? ☐ YES ☐ NO If yes, please attach test results.

Comments: _____

Developmental screening test(s) completed:

Test(s) used: _____ Date: _____ Result: _____

Please attach any developmental screenings, assessments, subspecialty consults, or allied health assessments that may be helpful in determining this child's eligibility and/or early intervention needs.

Signature: _____ Date: _____ Name: _____
Primary Care Provider or Designated Representative — Print

Address: _____ Telephone: _____ FAX: _____

UPLOAD ADDITIONAL DOCUMENTS

SUBMIT FORM VIA EMAIL

PRINT RESET

UPDATED 2022