

# EarlySteps Referral Form



**SPOE USE ONLY**

RECEIVED & ENTERED:

RECEIVED & ENTERED BY:

ACKNOWLEDGEMENT SENT:

ASSIGNED INTAKE COORDINATOR:

REFERRAL DETAILS:

RELATED SERIAL NUMBER:

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:**

FIRST MI LAST

**Sex:** Male Female

**Date of Birth:**

MM/DD/YYYY

**Medicaid Number:**

**SSN:**

**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:**

HOME

WORK

CELL

**Email:**

**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**

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| <p><b>Suspected Developmental Delay</b></p> <p>Cognitive</p> <p>Social/Emotional Adaptive</p> <p>Motor: Fine Gross</p> <p>Language: Receptive Expressive</p> <p><b>ICD-10 Code</b></p> <p><b>Source of Screening Tool:</b></p> <p><b>Orthopedic Impairment</b></p> <p><b>ICD-10 Code</b></p> <p><b>Autism</b></p> <p><b>ICD-10 Code</b></p> <p><b>Traumatic Brain Injury</b></p> <p><b>ICD-10 Code</b></p> <p><b>Seizure Disorder</b></p> <p><b>ICD-10 Code</b></p> <p><b>Sensory Impairment</b></p> <p><b>ICD-10 Code</b></p> <p>Hearing (Describe Below)</p> <p>Vision (Describe Below)</p> | <p><b>Genetic Disorder</b></p> <p>Spina Bifida/Neural Tube Defect</p> <p>Down Syndrome</p> <p>Hydrocephaly</p> <p>Microcephaly</p> <p>Cleft Lip/Palate</p> <p>Stroke due to Sickle Cell Anemia</p> <p>Metabolic Disorder</p> <p><b>ICD-10 Code</b></p> <p><b>Congenital/Neonatal Disorder</b></p> <p>Bacterial meningitis</p> <p>Cytomegalovirus (CMV)</p> <p>Herpes</p> <p>Rubella</p> <p>Syphilis</p> <p>Toxoplasmosis</p> <p><b>ICD-10 Code</b></p> <p><b>Neuromuscular Disorder</b></p> <p>Cerebral Palsy</p> <p>Muscular Dystrophy</p> <p><b>ICD-10 Code</b></p> | <p><b>Birth History</b></p> <p><b>ICD-10 Code</b></p> <p>Low birth weight grams</p> <p>Respiratory distress</p> <p>Ventilator support</p> <p>Intraventricular Hemorrhage</p> <p>Birth Asphyxia</p> <p><b>NICU Treatment</b></p> <p>Hospital stay: days</p> <p>Gestation: weeks</p> <p><b>Exposure to Toxic Substances</b></p> <p>Drugs</p> <p>Alcohol</p> <p>Elevated Blood Lead Level Requiring Chelation:</p> <p>UG/DL /</p> <p><b>ICD-10 Code</b></p> <p><b>Other/Explanation:</b></p> |
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**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

Initial Health Summary  
Health Summary Update

## Health Summary



**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: \_\_\_\_\_ Gestational Age: \_\_\_\_\_ Length of Hospital Stay: \_\_\_\_\_  
grams lbs/oz

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: \_\_\_\_\_