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 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#** _____**SSN:** _____-_____-_____

Race: ___White ___Black/African American ___Asian ___Native Hawaiian/Other Pacific Islander ___American Indian/Alaska Native __ Hispanic/Latino of any race ___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: _____**Address:** _____

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

How did you find out about 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)

- ☐ Vision (Describe)

☐ **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

ICD10-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 Mail or Fax to: Easterseals Louisiana EarlySteps office at:
1103 Hudson Lane, Suite 3, Monroe, LA 71201
Fax: 318-322-1549 Phone: 318-322-4788

☐ 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/Family Support 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: (Circle) 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: _____