

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

<input type="checkbox"/> Suspected Developmental Delay <input type="checkbox"/> Cognitive <input type="checkbox"/> Social/Emotional <input type="checkbox"/> Adaptive <input type="checkbox"/> Motor ___Fine ___Gross <input type="checkbox"/> Language ___Receptive ___Expressive ICD-10 Code: _____ Source of Screening Tool: _____ <input type="checkbox"/> Orthopedic Impairment ICD-10 Code: _____ _____ <input type="checkbox"/> Autism ICD-10 Code: _____ <input type="checkbox"/> Traumatic Brain Injury ICD-10 Code: _____ <input type="checkbox"/> Seizure Disorder ICD-10 Code: _____ <input type="checkbox"/> Sensory Impairment ICD-10 Code: _____ <input type="checkbox"/> Hearing (Describe) <input type="checkbox"/> Vision (Describe)	<input type="checkbox"/> Genetic Disorder <input type="checkbox"/> Spina Bifida/Neural Tube Defect <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Hydrocephaly <input type="checkbox"/> Microcephaly <input type="checkbox"/> Cleft Lip/Palate <input type="checkbox"/> Stroke due to Sickle Cell Anemia <input type="checkbox"/> Metabolic Disorder: _____ ICD-10 Code: _____ <input type="checkbox"/> Congenital/Neonatal Disorder <input type="checkbox"/> Bacterial meningitis <input type="checkbox"/> Cytomegalovirus (CMV) <input type="checkbox"/> Herpes <input type="checkbox"/> Rubella <input type="checkbox"/> Syphilis <input type="checkbox"/> Toxoplasmosis ICD10-Code: _____ <input type="checkbox"/> Neuromuscular Disorder <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Muscular Dystrophy ICD-10 Code: _____	<input type="checkbox"/> Birth History ICD-10 Code: _____ <input type="checkbox"/> Low birth weight _____ grams <input type="checkbox"/> Respiratory distress <input type="checkbox"/> Ventilator support <input type="checkbox"/> Intraventricular hemorrhage <input type="checkbox"/> Birth asphyxia <input type="checkbox"/> NICU Treatment <input type="checkbox"/> hospital stay = _____ days <input type="checkbox"/> gestation = _____ weeks Exposure to Toxic Substances <input type="checkbox"/> Drugs <input type="checkbox"/> Alcohol <input type="checkbox"/> Elevated Blood Lead level requiring chelation: ug/dl _____ / _____ ICD-10 Code: _____ Other/Explanation: _____ _____ _____ _____
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**Please Mail or Fax to: Easterseals Louisiana EarlySteps office at:
 2800 South MacArthur Drive, Suite E, Alexandria LA 71301
 Fax: 318-445-4990 Phone: 318-487-1165**

- 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: _____ 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: (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: _____