# 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:** _____ ____ _____ **Sex:** ___Male ___Female
First MI Last

**Date of Birth:** ____/____/_____ **Medicaid #** _____ **Social Security #:** _____-_____-_____

**Race** (Check *one* item, based on the family's self-report.)**:** __ Hispanic/Latino of any race *OR*
Non-Hispanic: ___White ___Black/African Amer ___Asian ___Native Hawaiian/Pac Islander ___Amer Indian/Alaska Native ___2 or more races

**Parent(s)/Guardian(s):** _____

**Address:** _____

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

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

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

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

**How did you find out about EarlySteps?** _____

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

## 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:** _____
  _____

- **Autism ICD-9 Code:**_____
- **Traumatic Brain InjuryICD-9 Code:**_____
- **Seizure Disorder ICD-9 Code:**_____
- **Sensory Impairment ICD-9 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-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:**_____
  - 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-9 Code:_____
**Other/Explanation:** _____
_____
_____
_____
_____

**Please Email, Mail or Fax to the regional System Point of Entry office nearest you:**

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Fax: (504) 595-3158
Email: jrodrigue@laeasterseals.com

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