

## Early Intervention Referral Form

*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 \_\_\_ White \_\_\_ Black/African American \_\_\_ Asian \_\_\_ Pacific Islander  
 \_\_\_ American Indian/Alaska Native

**Parent(s)/Guardian(s):** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **County:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phones:** (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ **email:** \_\_\_\_\_

**Insurance Carrier(s):** \_\_\_\_\_

**Insurance Identification #(s):** \_\_\_\_\_

**Covered Party(ies):** \_\_\_\_\_

**Primary Health Care Provider:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City/State/Zip:** \_\_\_\_\_ **Phone:** (\_\_\_\_) \_\_\_\_\_ **Fax:** (\_\_\_\_) \_\_\_\_\_

**Referred by:** \_\_\_\_\_ **Phone:** (\_\_\_\_) \_\_\_\_\_ **Fax:** (\_\_\_\_) \_\_\_\_\_

### Reason for Referral

<input type="checkbox"/> <b>Genetic Disorder</b> <input type="checkbox"/> Spina Bifida/Neural Tube Defect <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Hydrocephaly <input type="checkbox"/> Microcephaly <input type="checkbox"/> Fragile X <input type="checkbox"/> Cleft Lip/Palate <input type="checkbox"/> Stroke due to Sickle Cell Anemia <input type="checkbox"/> Metabolic Disorder: _____  <input type="checkbox"/> <b>Congenital/Neonatal Disorder</b> <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  <input type="checkbox"/> <b>Neuromuscular Disorder</b> <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> <b>Suspected Developmental Delay</b> <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  <input type="checkbox"/> <b>Orthopedic Impairment</b> _____  <input type="checkbox"/> <b>Autism</b>  <input type="checkbox"/> <b>Traumatic Brain Injury</b>  <input type="checkbox"/> <b>Seizure Disorder</b>  <input type="checkbox"/> <b>Sensory Impairment</b> <input type="checkbox"/> Hearing (Describe)  <input type="checkbox"/> Vision (Describe)	<input type="checkbox"/> <b>Birth History</b> <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  <b>Exposure to Toxic Substances</b> <input type="checkbox"/> Drugs <input type="checkbox"/> Alcohol <input type="checkbox"/> Elevated Blood Lead level requiring chelation: ug/dl _____/_____  <b>Other/Explanation:</b> _____ _____ _____ _____
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**For Early Intervention personnel use only:**

Date referral received by EI program: \_\_\_\_\_ Who received? \_\_\_\_\_  
 Date sent to Central Referral Unit: \_\_\_\_\_ Date received by CRU: \_\_\_\_\_  
 Person entering data into FSIS: \_\_\_\_\_ Date entered: \_\_\_\_\_  
 FSIS #: \_\_\_\_\_ District/Assigned to \_\_\_\_\_/  
 MDH ROI signed? \_\_\_ Yes \_\_\_ No \_\_\_ Refused \_\_\_ Attached