

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/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: _____ **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"/> 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"/> 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"/> 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 <input type="checkbox"/> Neuromuscular Disorder <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Muscular Dystrophy	<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 <input type="checkbox"/> Orthopedic Impairment _____ <input type="checkbox"/> Autism <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Sensory Impairment <input type="checkbox"/> Hearing (Describe) <input type="checkbox"/> Vision (Describe)	<input type="checkbox"/> Birth History <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 _____ / _____ Other/Explanation: _____ _____ _____ _____
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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

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