Mississippi State Department of Health, First Steps Early Intervention Program, Post Office Box 1700, Jackson, MS 39215-1700
Phone: 1-800-451-3903 or (601) 576-7427; Fax: (601) 576-7540

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

☐ **Genetic Disorder**
- ☐ Spina Bifida/Neural Tube Defect
- ☐ Down Syndrome
- ☐ Hydrocephaly
- ☐ Microcephaly
- ☐ Fragile X
- ☐ Cleft Lip/Palate
- ☐ Stroke due to Sickle Cell Anemia
- ☐ Metabolic Disorder:_____

☐ **Congenital/Neonatal Disorder**
- ☐ Bacterial meningitis
- ☐ Cytomegalovirus (CMV)
- ☐ Herpes
- ☐ Rubella
- ☐ Syphilis
- ☐ Toxoplasmosis

☐ **Neuromuscular Disorder**
- ☐ Cerebral Palsy
- ☐ Muscular Dystrophy

☐ **Suspected Developmental Delay**
- ☐ Cognitive
- ☐ Social/Emotional
- ☐ Adaptive
- ☐ Motor __Fine __Gross
- ☐ Language __Receptive __Expressive

☐ **Orthopedic Impairment** _____

☐ **Autism**

☐ **Traumatic Brain Injury**

☐ **Seizure Disorder**

☐ **Sensory Impairment**
- ☐ Hearing (Describe)

- ☐ Vision (Describe)

☐ **Birth History**
- ☐ 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_____/_____

Other/Explanation: _____

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