

## Early Intervention Referral Form 814E

### Instructions

#### PURPOSE

The purpose of the Early Intervention Referral Form is to notify the First Steps Early Intervention Program of potentially eligible infants/toddlers who might have a developmental delay or a disability that is likely to result in a developmental delay if intervention services are not provided.

#### INSTRUCTIONS

1. The form should be completed for infants/toddlers birth to three years of age who have or are suspected of having a: disability, developmental delay, or diagnosed conditions that is likely to result in developmental delay(s).
2. Anyone (i.e., parents, health care providers, childcare providers) can make a referral to Early Intervention.
  - Healthcare providers who serve infants/toddlers from birth to age three are required by state and federal regulations to make referrals **within seven days** of determining that an infant/toddler is possibly in need of early intervention services.
3. Referrals should be made/sent directly to the Early Intervention Central Office by:
  - a. **Fax:** (601)-576-7540 or
  - b. **Mail:** Mississippi State Department of Health  
Early Intervention  
P.O. Box 1700  
Jackson, MS 39215-1700 or
  - c. **Phone:** 1-800-451-3903 or (601) 576-7427

**Please print the requested information in each blank (\*indicates required information)**

#### DEMOGRAPHIC DATA

**Child's Name\*:** Enter the Child's first, middle and last name.

**Sex\*:** Check if the child is a male or female.

**Date of Birth\*:** Enter the child's date of birth (mm/dd/yyyy).

**Medicaid#:** Enter the child's Medicaid# (if applicable).

**Social Security#:** Enter the child's Social Security#.

**Ethnicity\*:** Check one ethnicity (Hispanic/Latino or Non-Hispanic/Latino).

**Primary Language\*:** Indicate the primary language for the child (English, Spanish, or Other (specify)).

**Race\*:** Check child race based on family's self-report. More than one race may be chosen from the list (White, Black/African American, Asian, Pacific Islander and/or American Indian/Alaska Native).

**Parent(s)/Guardian(s)\*:** Enter the child's parent(s)/guardian(s) name.

**Address\*:** Enter the child's physical address (no PO Box address).

**City\*:** Enter the city that the child resides in.

**Zip code\*:** Enter the zip code for the address that was provided.

**County\*:** Enter the county that the child resides in.

**Phone #'s\*:** Enter the phone numbers (Home, cell or other) of the parent(s)/guardian of the child.

**Email:** Enter the email address of the parent(s)/guardian(s) of the child.

**Insurance Carrier (1)\*:** Enter the primary insurance company name that insures the child.

**Insurance Carrier (2):** Enter a secondary insurance company's name that insures the child.

**Insurance Identification # (1):** Enter the child's primary insurance identification #.

**Insurance Identification # (2):** Enter the child's secondary insurance identification #.

**Covered Party (1):** If applicable check which type the child has (Medicaid, CHIP, MSCAN (United Health Care or Magnolia Health)).

**Covered Party (2):** If applicable check which type the child has (Medicaid, CHIP, MSCAN (United Health Care or Magnolia Health)).

**Primary Health Care Provider\*:** Enter the primary agency and provider's name of the child.

**Address:** Enter the address of the primary health care provider.

**City:** Enter the city of the primary health care provider.

**State:** Enter the state of the primary health care provider.

**Zip:** Enter the zip code of the primary health care provider.

**Phone #'s:** Enter the primary health care provider's office and fax number.

**Email:** Enter the primary health care provider's email address.

**Referral Source:** Enter the name of the person who made the referral, what relationship (i.e., mother, grandparent, nurse) referral source has to the child and the referral source's phone #.

### **REASON FOR REFERRAL\***

Identify the main reason that the child is being referred to the program. If the child has a known medical condition (i.e., genetic disorder, sensory impairment, neurological disorder) that will result in a developmental delay check which primary medical condition the of child. If the child has no medical condition, but has possible developmental delays (i.e., speech, adaptive) check the suspected developmental delay box.

### **FOR EARLY INTERVENTION STAFF USE ONLY**

**Date Referral Received by EI Program:** Enter the date the EI program (Central Office or Local District) received the referral form.

**Date sent to Central Referral Unit:** If the referral form was received at the Local District enter the date that the referral was sent to Central Office.

**Who received referral:** Enter the name of the EI staff that received the referral form

**District Assigned to:** Enter the District that the referral form has been assigned to.

**Assign SC:** Enter the name of the service coordinator that will receive notice of the referral form.

### **OFFICE MECHANICS and FILING**

Information from the Early Intervention Referral Form will be entered into the Child Registry by a Central Office staff and the original referral form will be scanned into the child's file in the Child Registry. Once the original referral form is entered and scanned into the registry it will be shredded.

### **RETENTION PERIOD**

The scanned Early Intervention Referral Form shall remain in the child's Early Intervention Record until the participating agency is no longer required to maintain or no longer maintains that information under applicable Federal and State laws.

## 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 seven 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.

**Please Print**

**Child's Name:** \_\_\_\_\_ **Sex:**  Male  Female  
First MI Last

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Medicaid #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Social Security #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Ethnicity** (Check *one* item):  Hispanic/Latino  Non-Hispanic/Latino **Primary Language:**  English  Spanish  Other: \_\_\_\_\_

**Race** (based on the family's self – report):  White  Black/African American  Asian  Pacific Islander  American Indian/Alaska Native

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

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

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

**Phone #s:** (\_\_\_\_) \_\_\_\_ - \_\_\_\_ (\_\_\_\_) \_\_\_\_ - \_\_\_\_ (\_\_\_\_) \_\_\_\_ - \_\_\_\_ **Email:** \_\_\_\_\_  
Home Cell Other

**Insurance Carrier (1):** \_\_\_\_\_ **Insurance Carrier (2):** \_\_\_\_\_

**Insurance Identification # (1):** \_\_\_\_\_ **Insurance Identification # (2):** \_\_\_\_\_

**Covered Party (1):**  Medicaid  CHIP **Covered Party (2):**  Medicaid  CHIP  
 MSCAN ( United HealthCare  Magnolia Health)  MSCAN ( United HealthCare  Magnolia Health)

**Primary Health Care Provider:** \_\_\_\_\_  
Agency Provider's Name

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone #s:** (\_\_\_\_) \_\_\_\_ - \_\_\_\_ (\_\_\_\_) \_\_\_\_ - \_\_\_\_ **Email:** \_\_\_\_\_  
Office Fax

**Referral Source:** \_\_\_\_\_ (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Referral Made By Referral Type Referral Phone#

### Reason for Referral

<p><input type="checkbox"/> <b>Genetic Disorder/Chromosomal:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Sickle Cell Disease – confirmed</li> <li><input type="checkbox"/> Inborn Error of Metabolism</li> <li><input type="checkbox"/> Other: (Examples: Williams Syndrome, Prader-Willie, Down syndrome) Specify: _____</li> </ul> <p><input type="checkbox"/> <b>Neonatal/Perinatal Disorders:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Congenital Infection: (Examples: CMV, HSV, Rubella, Syphilis, Toxoplasmosis, Bacterial Meningitis) Other (Specify): _____</li> <li><input type="checkbox"/> Intraventricular Hemorrhage (IHV) grade III and/or IV</li> <li><input type="checkbox"/> Hypoxic Ischemic Encephalopathy</li> <li><input type="checkbox"/> Ventilator Support (duration _____)</li> </ul> <p><input type="checkbox"/> <b>Sensory Impairment:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <b>Hearing:</b></li> <li><input type="checkbox"/> Bilateral <input type="checkbox"/> Unilateral</li> <li><input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Profound</li> <li><input type="checkbox"/> <b>Vision Impairment:</b> _____</li> </ul> <p><input type="checkbox"/> <b>Severe Orthopedic Impairment:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Specify: _____</li> </ul> <p><input type="checkbox"/> <b>Exposure to Environmental Toxins:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lead (≥ 15µg/dL)</li> </ul>	<p><input type="checkbox"/> <b>Neurological Disorders:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cerebral Palsy</li> <li><input type="checkbox"/> Neural Tube Defect (Example: Spina Bifida) Specify: _____</li> <li><input type="checkbox"/> Seizure Disorder</li> <li><input type="checkbox"/> Muscular Dystrophy</li> <li><input type="checkbox"/> Encephalopathy</li> <li><input type="checkbox"/> Traumatic Brain Injury</li> <li><input type="checkbox"/> Hydrocephalus</li> <li><input type="checkbox"/> Microcephaly</li> <li><input type="checkbox"/> Other (Specify): _____</li> </ul> <p><input type="checkbox"/> <b>Mental/Social/Emotional Health Disorders:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Autism Spectrum Disorder</li> <li><input type="checkbox"/> Anxiety Disorder</li> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Adjustment Disorder</li> <li><input type="checkbox"/> Disorders of Affect</li> <li><input type="checkbox"/> Sleep Behavior Disorder</li> <li><input type="checkbox"/> Deprivation/Maltreatment Disorder</li> <li><input type="checkbox"/> Other (Specify): _____</li> </ul> <p><input type="checkbox"/> <b>Prenatal</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Alcohol</li> <li><input type="checkbox"/> Drugs</li> </ul> <p><input type="checkbox"/> <b>Other Identified Conditions or Diagnosis:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Specify: _____</li> </ul>	<p><input type="checkbox"/> <b>Suspected Developmental Delay: (check all that apply)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Physical: <input type="checkbox"/> Fine Motor <input type="checkbox"/> Gross Motor</li> <li><input type="checkbox"/> Cognitive</li> <li><input type="checkbox"/> Adaptive/Behavioral</li> <li><input type="checkbox"/> Social/Emotional</li> <li><input type="checkbox"/> Communication (Speech/language)</li> </ul> <p><b><u>Tracking Status:</u></b></p> <p><input type="checkbox"/> <b>Prematurity:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Very Low Birth Weight (VLBW) &lt;1500 grams</li> <li><input type="checkbox"/> Gestational Age ≤ 32 weeks</li> </ul> <p><input type="checkbox"/> <b>NICU ≥ 10 days</b></p> <p><input type="checkbox"/> <b>Nutritional:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Growth Restriction</li> <li><input type="checkbox"/> Failure to Thrive</li> <li><input type="checkbox"/> Swallowing/Feeding Problems</li> </ul> <p><input type="checkbox"/> <b>Child Abuse Prevention and Treatment Act (CAPTA) /DHS Custody</b></p>
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Date Referral Received by EI Program: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Sent to Central Referral Unit: \_\_\_\_/\_\_\_\_/\_\_\_\_

Who Received Referral: \_\_\_\_\_ District Assigned to: \_\_\_\_\_ Assign SC: \_\_\_\_\_