First Steps

First Steps Early Intervention System Referral Form

Child Information

Name _____ DOB _____ Age _____ months

Gender (circle) M or F Physician _____ Zip Code _____

Address _____ City _____, IN

County (circle) Clark Crawford Dubois Floyd Gibson Harrison Orange Perry Pike Posey Scott Spencer Vanderburgh Warrick Washington

Family Information

Has family been informed of this referral? Y or N

Name _____ Phone _____ Phone _____

Relationship (circle) Mother Father Grandparent Foster Parent Other Guardian

***Specific* Reason for Referral:**

Does child have a diagnosis?

Diagnosis _____ ICD-9 _____

Primary Referral Source

Name _____

Phone _____ Fax _____

Relationship to child (circle) Parent Guardian Physician Hospital DCS Healthy Families WIC Other _____

Secondary Referral Source

Name _____

Phone _____ Fax _____

Relationship to child (circle) Parent Guardian Physician Hospital DCS Healthy Families WIC Other _____

Form Completed by: _____ Date: _____

Return to: First Steps of Southern Indiana, PO Box 547, Corydon, IN 47112

Phone 1-800-941-2459 Fax 1-877-474-2285

SPOE office use: Date Rec'd _____ Entered _____ IC _____ ID _____