

BIRTH TO THREE EARLY INTERVENTION INTAKE/REFERRAL FORM

Information requested must be **COMPLETED** before Referral can be **PROCESSED**

Forward Referral within two (2) Days of identification to: Intake & Referral

Early Steps - (DEI)
 Sacred Heart Hospital
 5150 Bayou Blvd., Suite 1-N
 Pensacola, FL 32503-2158
Phone: (850) 416-7656 FAX: (850) 416-7348

Parent(s) requested Referral Parent(s) permission obtained for Referral MR# _____
(For DEI Office Use Only)

CHILD'S INFORMATION

Child's Name: _____ AKA: _____
(Print Last, First, Middle) (Also Known As)

Child's SSN: _____ SEX: Male Female DOB: ____/____/____
 Ethnic Origin: Black White Hispanic Haitian Cuban Native American Unknown Other

Medicaid & Authorization # _____ Private Insurance & Policy # _____

Birthplace & Hospital _____ Primary Language (in home) _____

PARENT'S/GUARDIAN'S INFORMATION

Mother's Name: _____ SSN: _____ DOB: ____/____/____
(Print Last, First, MI)

Father's Name: _____ SSN: _____ DOB: ____/____/____
(Print Last, First, MI)

Marital Status: Married Divorced Separated Never Married Widowed Living Together Unknown

Primary Caregiver: _____ Relationship: _____
(Parent, Fostercare, Guardian, Relative Placement)

Street Address - (Apt. No) _____ City _____ County _____ State _____ Zip Code _____

e-mail address: _____

(____) _____ (\$) _____
 Phone# (Home) Phone# (Contact/Work/Cell) Family Income (Annual) Adults Children
(Household Size)

REFERRAL INFORMATION

Reason(s) for Referral (please explain concerns below as appropriate):

- Gross Motor Delay _____
- Fine Motor Delay _____
- Speech Delay _____
- Neurological _____
- Additional/Screening Information (attach available reports): _____
- Sensory Impairment _____
- Genetic Impairment _____
- Congenital Anomaly _____
- Other _____

Primary Care Physician _____ Street Address _____ Phone# _____

Referred By: _____ Name - Program/Agency _____ Phone # _____

Form Completed By: _____ Date: ____/____/____

INFORMATION TO BE COMPLETED BY EARLY STEPS/DEI PROGRAM

Child's Unique ID # _____
 LSC: _____ ICD9 CODE: _____ = 45 DAYS RE-REFERRAL: Y / N