EARLY STEPS REFERRAL FORM 2021

CHILD'S NAME	DOB:

☐ Biological ☐ Adoptive ☐ Foster ☐ Guardian ☐ **Interpreter needed**

PARENT/GUARDIAN

NAME:	ADDRESS:		
Phone #	**CITY:**	**STATE:** FLORIDA	**ZIP:**
Alternate #	**Emergency Contact:**	**Telephone #**	**Relationship:**

☐ Physician ☐ CMS ☐ Protective Investigator ☐ Other:

Referral Source:

Name:	Address:		
Phone#	City:	State:	Zip:
Fax #			
	Is the family aware of the referral? ☐ Yes	☐ No	

REASON FOR EARLY STEPS REFERRAL:

Suspected Developmental delay or concern (Please indicate area(s) of concern):

☐ Cognition ☐ Physical (Gross motor or Fine motor) ☐ Adaptive/Self Help

☐ Communication ☐ Social/Emotional ☐ Other: _____

Notes:

For Physician's Use Only - Complete ***ONLY*** if child has an at risk condition or an established condition* (e.g.: Traumatic Brain Injury, Birth Anomalies, Neonatal Seizures, Down Syndrome, Cerebal Palsy, Autism, etc.)

Diagnosis:	ICD10:

This diagnosis places the child at risk and needs monitoring or is an established condition that has a high probability of resulting in developmental delay. This child should be considered eligible for Part C of IDEA (Individuals with Disabilities Education Act).

Physician's Signature: _____ Date: _____

Physician's office ID Stamp	Local Early Steps Office
	SPACE COAST EARLY STEPS **1264 US HWY 1 Ste 103** **Rockledge, Florida 32955** **Tel: 321-634-3688** **Direct referrals to: Ext 5863** **Fax: 321-878-3103**