Early On® Michigan Referral Form / Child Status Fax Back Form (Page 1)

Medical Provider Information (Completed by Provider's Office. Fax to Early On: 1-517-668-0446)

Referring Medical Provider: ______________________________________ Date: _____________________________

Phone: (_____)______________________________ Fax: (_____)____

Office Contact: ______________________________ E-Mail: ____

I would like a copy of:

Individualized Family Service Plan (IFSP): Yes _____ No ____ and/or Evaluation: Yes _____ No ______

I am the Primary Care Provider: Yes _____ No _____

Parent/Guardian has signed an authorization that allows sharing of protected health information

Parent / Guardian Information

Parent Foster Parent Grandparent Adoptive

Legal Guardian Other / Relative (specify): _________________________________

Name: ____

Phone: Home (_____)_________________ Cell (_____)__________________ Work (_____)________________

Address: ____

City: _________________________ Zip: _________________ E-mail:____________________________________

Child Information

Address: ____

Birth Date: __________________________________ Gender: Male Female

Premature: No Yes: Weeks gestation _________ Low Birth Weight: No Yes: _______________

Reason(s) for Referral (please check all that apply):

_____ Identified condition or diagnosis (e.g., Down syndrome): ____

_____ Suspected developmental delay (Please circle areas of concern):

Motor/Physical Cognitive Social/Emotional Speech/Language Behavior Other

_____ Other (Please describe):____

Please check the following records that have been included:

_____ Screening Results (circle): ASQ 3 ASQ SE MCHAT Denver PEDS Other
_____ Health Status
_____ Vision/Hearing Status
_____ List of pertinent diagnoses

Early On® Michigan Referral Form / Child Status Fax Back Form (Page 2)

Fax Back / Child Referral Status – To be completed by *Early On*.

(Fax to Primary Care Provider if they are not the referring medical provider.)

Child's Name: ____ Birth Date: ______________________

Eligibility Determination

_____ I do not have authorization to share information

_____ Unable to contact this family. Please re-assess need for referral

_____ Family Declined evaluation

_____ Evaluation completed; child did NOT meet eligibility criteria and WAS NOT enrolled for services

_____ Evaluation completed; child found eligible; unable to contact family for services

_____ Evaluation completed; child found eligible for services; parent/guardian declined enrollment

_____ Evaluation completed; child met eligibility criteria (see below) and WAS enrolled for services

_____ Established Medical Condition ____

And / Or

_____ 20% delay in at least one developmental domain

_____ Cognitive _____ Communication _____ Social-Emotional

_____ Physical (including vision and hearing) _____ Adaptive/Self-Help

Child is Eligible for: _____ *Early On* ______ Michigan Special Education

Services

_____ Social Work Services _____ Nutrition _____ Family Training _____ Speech _____ PT

_____ Assistive Technology _____ Audiology _____ Special Instruction _____ OT _____ Other

Referrals

_____ Children's Special Health Care _____ Community Mental Health _____ Great Parents, Great Start

_____ Parent Support Groups (specify) _____ 0-3 Secondary Prevention _____ MIHP _____ Other

Early On Contact Information

Intermediate School District ____________________________ *Early On* Provider Agency________________

Name: _______________________________________ Phone: ____________________________________

E-Mail: ______________________________________ Date: _____________________________________

Referral/Fax Back 4/30/10 TK