

# Promoting Child Development Screening II Early On<sup>®</sup> Referral/Status Update



1-800-EarlyOn (327-5966)

## I. Referral Information. Section I is to be completed by the Provider. Fax to Early On Public Awareness: 1-517-668-0446. This form may also be e-mailed to: [eoreferral@edzone.net](mailto:eoreferral@edzone.net).

Referring Physician: \_\_\_\_\_ Date: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
E-mail: \_\_\_\_\_

I would like a copy of the **Individualized Family Service Plan (IFSP)**  Yes  No

### Parent/Guardian Information

Parent  Grandparent  Foster parent  Aunt/Uncle  Legal Guardian  Other

Name: \_\_\_\_\_  
Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Case Worker (if appropriate): \_\_\_\_\_ Local School District: \_\_\_\_\_

### Child Information

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  Male  Female  
Was Child premature: No  Yes  born at \_\_\_\_\_ weeks gestation.  
Birth weight: \_\_\_ lbs. \_\_\_ oz. or \_\_\_ weight in grams  
Briefly Describe Concerns or Screening Results Below:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

## II. Eligibility Determination. Completed by local Early On program. Please fax back to the Provider.

- Unable to contact this family. Please re-assess need for referral.
- Family declined evaluation.
- Evaluation completed; child was found to be **not eligible** for Early On (Part C) services at this time.
- Evaluation completed; child found **eligible** for services; parent/guardian declined enrollment or unable to contact.
- Evaluation completed; child found to be **eligible** for Early On (Part C) services based on the following:
  - Established Medical Condition \_\_\_\_\_
  - 20% delay in at least one developmental domain
    - Cognitive  Communication  Social-Emotional
    - Physical (including vision and hearing)  Adaptive/Self-Help

### Services Child is receiving

PT  Family Training  Audiology  Speech  Assistive Technology  
 OT  Special Instruction  Nutrition  Nutrition  Other

### Referrals made by Early On

Children's Special Health Care  Community Mental Health  Great Parents, Great Start  
 Parent Support Group  0-3 Secondary Prevention  Other (specify)

### Early On Contact Information

Intermediate School District \_\_\_\_\_ Early On Provider Agency: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_