FIRST STEPS
KENTUCKY'S EARLY INTERVENTION SYSTEM
8/30/2018

312 Whittington Parkway, Ste 020
Phone: 502-429-1249
Fax:502-429-1255

Referral Form

Parent/Child Contact Information

Child's Name: Date of Birth: TOTS ID:
Gender: ☐Male ☐Female Race: Medicaid Card #
Hospital of Birth (If Known): Gestational Age:
Child resides with: ☐Parent ☐Legal Guardian ☐Foster Family ASQ #:
Name:
Address:
Home Phone: Other Phone:
If family has no phone, contact person:
Relationship to child: Phone:
Primary Language spoken in the home:
Is child currently being seen by a NICU Program? ☐Yes ☐ No
If yes, location of NICU Program:

Foster Parent Contact Information *(if applicable)*

Foster Parent(s): Phone:
Foster Parent(s) Address:
How long has the child resided at this residence? Surrogate/Advocate? ☐ Yes ☐ No
If yes, Name: Phone:
Assigned DPP Caseworker: Phone: E-mail:
Case Open? ☐Yes ☐No CAPTA? ☐Yes ☐ No
Legal Status of child: ☐Parental custody, rights intact ☐Foster care, biological rights intact ☐Foster care, parent rights terminated Other/Explain:

Referral Source Contact Information

Your Name (Required): Date of Referral:
Is the family aware you are making the referral?☐Yes ☐ No
Agency Name: University of Louisville Pediatrics Phone:
Your Address: Fax:
Your e-mail:

Reason(s) for Referral to Early Intervention

First Steps, Kentucky's Early Intervention System, provides developmental intervention services for children ages birth to three. The children qualifying for these services have a significant developmental delay or have medical conditions which put them at risk for significant delays in their development or a disability.

Please Check all suspected areas of developmental delay or concern that apply:

☐ Behavior ☐ Cognitive ☐ Motor/Physical ☐ Social/Emotional ☐ Speech Language
(Describe):
☐ Other (Describe):
☐ Health Concerns (Describe):
Audiological Exam completed? ☐ Yes ☐ No
Name of Audiologist:
Diagnosed Condition expected to lead to developmental delay:
ICD- Code(s):

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The cost of printing was paid from state funds through the Department for Public Health, First Steps Program, pursuant to KRS 57.375

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Consent to Release/Obtain Information

Child's Name: _____ **DOB:** _____ **TOTS ID#:** _____

Listed below are a number of agencies that provide services for children and their families. I am putting my initials next to the agencies that I want to share information. I understand that these agencies will use and keep information confidential about my child. **I give my consent, as the parent/guardian of the minor child, to the agencies identified below to share the information that I have indicated. The purpose of this exchange of information is to help coordinate services, provide appropriate programs, and to make sure that my child and family get services as quickly as possible.**

Parent Initials	Agency/Program	Contact Person	Address	**Type of Information:** *Program Eligibility, Financial Information, Medical Records, including diagnosis, discharge summary, reports for: Vision, Audiology, Speech therapy, Physical therapy, Occupational therapy, and/or Developmental intervention, IFSP, Other: specify*	Timeframe/ Date of Service	Obtain	Release
	CCSHCN (Commission for Children with Special Health Care Needs)						
	EHDI (Early Hearing Detection & Intervention/Newborn Hearing Screening Program)						
	KY Birth Surveillance Registry						
	KY Newborn Screening						
	HANDS (Health Access Nurturing Development Services)						
	Hospital *(specify)*						
	Local Health Department						
	School District *(specify)*						
	Early Head Start						
	DCBS Office						

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Child's Name: _____ **DOB:** _____ **TOTS ID#:** _____

Initials	Agency/Program	Contact Person	Address	Type of Information:	Timeframe/ Date of Service	Obtain	Release
	Other: *(specify)* University of Louisville Pediatrics			Clinic notes, developmental assessments, etc.			
	Other: *(specify)*						
	Other: *(specify)*						
	Other: *(specify)*						

This information is needed for the following purposes: (check all that apply)

☐ Establish First Steps Eligibility
☐ Treatment, payment, healthcare operations
☐ Provide data for state and federal reports
☐ Develop an Individualized Family Service Plan
☐ Facilitate transition to Part B services at age 3
☐ Other: specify _____
☐ Coordinate, monitor and implement First Steps services

This consent for disclosure is valid until: ____/____/____.

Informed Consent

I understand that:

1) I have the right to withdraw my consent at any time by writing to my service coordinator, except to the extent that it has already been acted upon;
2) I have the right to inspect and copy the information to be shared;
3) If I do not give my consent to share information, the agencies may not be able to determine First Steps eligibility, develop an Individualized family service plan, provide early intervention services or pay for that service, coordinate, monitor and implement services and/or facilitate transition; and
4) I am providing my consent voluntarily and I understand the information on this form.
5) A copy of this form shall be as valid as the original.

Signature of Parent/Guardian: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Notice to Receiving Agency/Person: Under the provisions of the Family Education Rights and Privacy Act, 20 USC 1232g, and the Health Insurance Portability and Accountability Act of 1996, information collected hereunder may not be re-disclosed unless the person who consented to this disclosure specifically consents to such re-disclosure or the re-disclosure is allowed by law.

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