Early Steps Referral Form

Children Ages Birth to 3 Years

Information Received By: _____ Date: _____

Referred By: _____ Phone: _____ Email: _____

Referring Source: _____

Has the parent/legal guardian/caregiver been informed of the referral? ☐ Y ☐ N

Child's Name: _____ **DOB:** _____ **Age:** _____

Sex: ○ M ○ F Language Spoken at Home: _____ Currently enrolled in subsidized childcare? ○ Y ○ N

Race(s) (circle all that apply): ○ American Indian / Alaskan Native ○ Asian ○ Black/African American ○ Native Hawaiian/Pacific Islander ○ White Is your child Hispanic/Latino? ○ Y ○ N

☐ Parent ☐ Foster Parent ☐ Relative ☐ Guardian: _____

Home Address: _____ Apt: _____ Email: _____

City: _____ State: FL Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Alternative Contact Name: _____ Relationship: _____ Phone: _____

Is the child involved with ChildNet? ☐ Y ☐ N

Child Covered by Health Insurance: ☐ Y ☐ N ☐ Unknown Medicaid # _____ Plan _____

Private Insurance: ☐ Y ☐ N Name of Insurance Plan: _____ Policy #: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Developmental Concerns: ☐ Communication ☐ Motor ☐ Self-Help ☐ Cognitive ☐ Social/Emotional

☐ Behavioral ☐ Vision Related Diagnosis ☐ Hearing Related Diagnosis ☐ Other: _____

Currently Receiving Developmental Services: ☐ Y ☐ N ☐ Physical Therapy ☐ Speech Therapy ☐ Occupational Therapy

☐ Behavioral Services ☐ Unknown Where? _____

Child has a Medical Diagnosis ☐ Y ☐ N What: _____

Comments: _____

_____

_____

Fax to Early Steps at CDTC at 954-779-2316
or email to cdtc_ESIntake@BrowardHealth.org

CDTC Use Only:

Service Coordinator: _____