First Steps Early Intervention System Referral Form

Child Information

Name _____ DOB _____ Age _____ months

Gender (circle) M or F Physician _____ Zip Code _____

Address _____ City _____, IN
County (circle) Clay Daviess Greene Knox Martin Owen Parke Putnam Sullivan Vigo Vermillion

Family Information Has family been informed of this referral? Y or N

Name _____ Phone _____ Phone _____
Relationship (circle) Mother Father Grandparent Foster Parent Other Guardian

***Specific* Reason for Referral:**

Does child have a diagnosis?

Diagnosis _____ ICD-10 _____

Primary Referral Source

Name _____

Phone _____ Fax _____

Relationship to child (circle) Parent Guardian
Physician Hospital DCS Healthy Families
WIC Other _____

Secondary Referral Source

Name _____

Phone _____ Fax _____

Relationship to child (circle) Parent Guardian
Physician Hospital DCS Healthy Families
WIC Other _____

Form Completed by: _____ Date: _____
Return to: First Steps of West Central Indiana, 4130 S 7th Street, Terre Haute, IN 47802
Phone 1-877-860-0413 Fax 1-866-395-6034

SPOE office use: Date Rec'd _____ Entered _____ IC _____ ID _____