| BDR | GR | PHRM |
|---|---|---|
| | | |

MSDH use only

# Child & Adolescent Health Referral Form

***Per federal regulations and state policies, referrals should be made as soon as possible, but not later than seven (7) days, after determining an infant, toddler, or child is in possible need of services.***

Child's Name: _____ _____ _____ Sex: ☐ Male ☐ Female
*First* *M* *Last*

Date of Birth: ____/____/____ Social Security Number: ____-____-____ CPS Custody/CAPTA: ☐ Y ☐ N

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ White ☐ 2 or more

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Parent(s)/Legal Guardian(s) Name: _____ Phone: _____
*Last, First* ☐ *Home* ☐ *Cell* ☐ *Work*

Physical Address: _____ Phone: _____
☐ *Home* ☐ *Cell* ☐ *Work*

City: _____ County: _____ Zip Code: _____ Phone: _____
☐ *Home* ☐ *Cell* ☐ *Work*

Primary Care Provider/Pediatrician: _____ Medicaid Client: ☐ Y ☐ N

Referral Source (Relationship): _____ Phone: _____

## Referral:

☐ First Steps Early Intervention (Ages 0-3 Years) ☐ CYSHCN Services (Ages 0-21 Years)

## Referral Concerns:

### ESTABLISHED DIAGNOSIS

- ☐ Blood Disorders
  *Specify*: _____
- ☐ Cardiac Disorders
  *Specify*: _____
- ☐ Craniofacial Disorders
  *Specify*: _____
- ☐ Endocrine Disorders
  *Specify*: _____
- ☐ Ear/Nose/Throat Disorders
  *Specify*: _____
- ☐ Eye Disorders
  *Specify*: _____
- ☐ Genetic/Chromosomal Disorders
  *Specify*: _____
- ☐ Malformation of Organ System
  *Specify*: _____
- ☐ Neurological Disorders
  *Specify*: _____
- ☐ Orthopedic Disorders
  *Specify*: _____
- ☐ Perinatal/Neonatal Disorders
  - ☐ Congenital Infection (e.g., CMV, HSV, Rubella, Syphilis, Zika Virus)
  - ☐ Very Low Birth Weight (<1500 g)
  - ☐ Very Preterm Birth (<32 weeks)
  - ☐ Other: _____

### OTHER CONCERNS

- ☐ Autism Spectrum Disorder
- ☐ Exposure to Toxic Substances
  - ☐ Lead (≥ 15 µg/dL)
  - ☐ Prenatal exposure to alcohol
  - ☐ Prenatal exposure to drugs (prescription and non-prescription)
- ☐ Mental/Behavioral Health Concern
  *Specify*: _____
- ☐ NICU ≥ 10 days
- ☐ Nutritional Concern
  - ☐ Growth Restriction
  - ☐ Failure to Thrive
  - ☐ Swallowing/Feeding Problem
- ☐ Sensory Impairment
  - ☐ Hearing Impairment
  - ☐ Visual Impairment
- ☐ Suspected Developmental Delay
  - ☐ Physical: *Specify*
    - ☐ Fine Motor
    - ☐ Gross Motor
  - ☐ Communication: *Specify*
    - ☐ Receptive
    - ☐ Expressive
  - ☐ Cognitive
  - ☐ Adaptive/Daily Living
  - ☐ Social-Emotional
- ☐ Other: _____

### COORDINATED CARE NEEDS

***Use ONLY for referrals for CYSHCN Services***

- ☐ Community Agency Referral (e.g., mental health needs, other health supports)
- ☐ Follow-up for Missed Appointments (e.g., well child, chronic dx, subspecialist)
- ☐ Insurance Application Assistance
- ☐ Legal/Judicial Issues or Concerns
- ☐ Pharmaceutical Assistance
- ☐ Referral to Subspecialty
- ☐ Respite Care
- ☐ Self -Management Assessment
- ☐ Shared Plan of Care
- ☐ Social Service Referral (e.g., food, housing)
- ☐ Transition Planning/Services
  - ☐ Independent Living/Workforce
  - ☐ Medical Transition to Adult Care
  - ☐ Other: _____
- ☐ Transportation
- ☐ Other: _____

## Comments:

Date Received by EIP: ____/____/____ Who Received Referral: _____ District Assigned to: _____

Date Received by CYSHCN: ____/____/____ Who Received Referral: _____ Assigned CC: _____

**Mail:** Mississippi State Department of Health, 570 East Woodrow Wilson, P.O. Box 1700, Jackson, MS 39215

**Phone:** Early Intervention: 601-576-7427 or 1-800-451-3903 / CYSHCN: 601-576-7281 or 1-800-844-0898

**Fax:** Early Intervention: 601-576-7540 / CYSHCN: 601-5767296

*Form No. 1037*
*New 4/1/2017*

# Child and Adolescent Health Referral – Form 1037

Instructions

## PURPOSE

The purpose of the Child and Adolescent Health Referral Form is to notify (1) the First Steps Early Intervention Program of potentially eligible infants and toddlers who may have a developmental delay or a disability likely to result in a developmental delay if early intervention services are not provided and/or (2) the Children and Youth with Special Health Care Needs (CYSHCN) Services Program of potential eligible children and youth who have a special health care need requiring Care Coordination to assist with navigating care systems, facilitating care needs, and advocacy. *Note: Completion of a referral does not guarantee the infant, child, or youth will be eligible for services.*

## INSTRUCTIONS: *First Steps Early Intervention Program*

1. The form should be completed for any infant or toddler ages birth to three years who has or is suspected of having a disability, developmental delay, or diagnosed condition likely to result in developmental delay without intervention.
2. Anyone with knowledge of the infant or toddler may make a referral to the First Steps Early Intervention Program, including parents, health care providers, and child care providers. *Note: Health care providers serving infants and toddlers ages birth to three years of age are required by federal regulations and state policies to complete a referral* ***within seven days*** *of determining an infant or toddler is potentially in need of early intervention services.*
3. Referrals should be made to the **Early Intervention Central Referral Unit** by:
    a. **Fax:** (601)-576-7540 or
    b. **Phone:** (601) 576-7427 or 1-800-451-3903
    c. **Mail:** Mississippi State Department of Health
    Early Intervention, O-204
    P.O. Box 1700
    Jackson, MS 39215-1700

## INSTRUCTION: *Children and Youth with Special Health Care Needs Services*

1. This portion of form should be completed for infants, children, and youth ages birth to 21 years who have a diagnosed condition that falls under the Children and Youth with Special Health Care Needs (CYSHCN) guidelines. (See the *Care Coordination Manual*.)
2. Anyone with knowledge of the infant, child, or youth may make a referral for CYSHCN Services, including parents, health care providers, and child care providers. *Note: Health care providers are requested to complete a referral* ***within seven days*** *of determining an infant, child, or youth with a special health care need is potentially in need of Care Coordination Services.*
3. Referrals should be made to the **CYSHCN Services Office** by:
    a. **Fax:** (601)-576-7296 or
    b. **Phone:** (601) 576-7281 or 1-800-844-0898
    c. **Mail:** Mississippi State Department of Health
    CYSHCN Services, U-120
    P.O. Box 1700
    Jackson, MS 39215-1700

**Please print/type the requested information in the space provided**

***Demographic Information***

- **Child's Name:** Record the child's current first name, middle initial, and last name.
- **Sex:** Check the child's sex: Male or Female
- **Date of Birth:** Record the month, day, and year the child was born.

- **Social Security Number:** Record the child's social security number.
- **CPS Custody/CAPTA:** Check to indicate if the child is currently in Child Protective Services custody or is being referred according to the Child Abuse Protection and Treatment Act.
- **Race:** Check the child's race based on the family's self-report: American Indian/Alaska Native, Asian, Black/African American, Pacific Islander, and/or White. *Note: More than one race may be chosen.*
- **Ethnicity:** Check the child's ethnicity based on the family's self-report: Hispanic/Latino or Non-Hispanic/Latino
- **Primary Language:** Check the child's primary language spoken in the home: English, Spanish, or Other. *Note: If Other is selected, record the primary language in the space provided.*
- **Parent(s)/Legal Guardian(s) Name:** Record the current last and first name of the child's parent(s) and/or legal guardian(s).
- **Physical Address:** Record the physical street address where the child resides. *Note: Do not record a P.O. Box in place of the physical street address.*
- **City:** Record the city where the child resides.
- **County:** Record the county where the child resides.
- **Zip code:** Record the zip code where the child resides.
- **Phone:** Record up to three area codes and telephone numbers for the child's parent(s) and/or legal guardian(s). Check the appropriate box underneath to indicate the type of phone number recorded: Home, Cell, or Work.
- **Primary Care Provider/Pediatrician:** Record the name of the child's primary care provider or pediatrician.
- **Medicaid Client:** Check to indicate if the child is currently enrolled in Medicaid.
- **Referral Source (Relationship):** Record the name of the individual or facility (e.g., birthing hospital) completing the referral for the infant, child, or youth. Record the relationship of the referral source to the infant, child, or youth.
- **Phone:** Record the area code and telephone number for the referral source.

***Referral***

Check the box(es) to identify the referral for First Step Early Intervention and/or CYSHCN Services.

***Referral Concerns***

Check the reasons for the referral. If the child has a known medical condition or diagnosis (e.g., blood, craniofacial, or genetic disorders), check the appropriate box under *Established Diagnosis*. If there are other concerns for the child's condition or development (e.g., exposure to toxic substances, sensory impairments, or suspected developmental delay), check the appropriate box under *Other Concerns*.

**CYSHCN Services ONLY**: Check the appropriate box under *Coordinated Care Needs* (e.g., insurance application assistance, respite care, or transition services.

***Comments***

Record any additional information relevant for referral and follow-up.

**PROGRAM RECEIPT / ASSIGNMENT**

***Early Intervention Use Only***

**Date Received by EIP:** Record the month, day, year the referral form was received or completed by the Central Referral Unit or District Early Intervention Program.

**Who Received Referral:** Record the name of the Early Intervention staff person who received or completed the referral form.

**District Assigned to:** Record the number of the District Early Intervention Program to which the referred infant or toddler was assigned.

***CYSHCN Use Only***

**Date Received by CYSHCN:** Record the month, day, year the referral form was received or completed by the Central Office or District CYSHCN Services Program.

**Who Received Referral:** Record the name of the CYSHCN staff person who received or completed the referral form.

**Assigned CC:** Record the Care Coordinator's name to whom the referred child or youth was assigned.

## OFFICE MECHANICS / FILING

**Early Intervention ONLY:** Information from the *Child and Adolescent Health Referral Form* will be entered into the Child Registry by Early Intervention Central Referral Unit staff. A scanned copy of the referral form will be uploaded into the child's First Steps Information System (FSIS) file in the Child Registry. After the information from the referral form is entered into the Child Registry and a scanned copy uploaded into the child's FSIS file, the original form will be shredded.

**CYSHCN Services ONLY:** Information from the *Child and Adolescent Health Referral Form* will be entered into the Child Long-Term Care database by CYSHCN staff. A scanned copy of the referral form will be uploaded into the child's CYSHCN file in the Child Long-Term Care database. After the information from the referral form is entered into the Child Long-Term Care database and a scanned copy uploaded into the child's CYSHCN file, the original form will be shredded.

**Early Intervention and CYSHCN Services:** Information from the *Child and Adolescent Health Referral Form* will be entered into the first program's database (i.e., Child Registry or Child Long-Term Care database) by the first program's staff. The referral form will be scanned for upload into the child's (FSIS or CYSHCN) file. The scan will be sent via fax/scan to the second program. Information will be entered into the second program's database and the scanned copy uploaded into the child's (FSIS or CYSHCN) file. After information from the referral form is entered into both the Child Registry and Child Long-Term Care databases and scanned copies uploaded into the child's FSIS and CYSHCN files, the original referral form will be shredded.

**MSDH Use:** Referrals from (FR) or to (TO) Birth Defects Registry (BDR), Genetics Registry (GR), or Perinatal High Risk Management/Infant Services System (PHRM) are noted at the top of the form.

## RETENTION PERIOD

**Early Intervention:** The *Child and Adolescent Health Referral Form* will be stored electronically in the child's FSIS file in the Child Registry until the infant or toddler has exited the program and exceeds three years of age. After that time, the MSDH must inform the parents of this electronic referral form containing personally identifiable information collected, maintained, and used by the First Steps Early Intervention Program and explain that the information is no longer needed to provide early intervention services to the child per 34 CFR §303.416 *Destruction of information*. As required, the electronic record will be permanently deleted at the parents' request. Otherwise, the electronic record will be maintained without time limitations as part of the permanent record including the child's name, date of birth, parent contact information (including address and phone number), names of service coordinator(s) and EIS provider(s), and exit data (including exit year, age at exit, and any programs entered into upon exiting).

**CYSHCN:** The *Child and Adolescent Health Referral Form* will be stored electronically in the child's CYSHCN file in the Child Long-Term Care database until seven years after the child has exited the program.