Health Services Referral Form

Client's Name: _____ **Birth Name (if different)**: _____
First, Middle, Last Name *First, Middle, Last Name*

Client's Date of Birth: ____/____/____ **Sex**: ☐Male ☐Female ☐Intersex **CPS Custody/CAPTA**: ☐Y ☐N

Race: ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Hawaiian/Pacific Islander ☐White/Caucasian ☐Multi

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

If Child: Legal Guardian(s) Name: _____ **Home Phone:**
First and Last Name

Physical Address: _____ **Cell Phone:**

City: _____ **County**: _____ **Zip Code**: _____ **Work Phone:**

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

Referral Source (Relationship): _____ **Phone:**

Referral:

- ☐ Children & Youth with Special Health Care Needs (CYSHCN) Services (Ages 0-21 Years)
- ☐ First Steps Early Intervention (Ages 0-3 Years)
- ☐ WIC (Pregnant Women, Ages 0-5 Years)
- ☐ Healthy Moms Healthy Babies (HM/HB) (Pregnant Women, Ages 0-3 Months)
- ☐ Parents as Teachers (PAT) (Pregnant Women, Ages 0-5 Years)
- ☐ Early Hearing Detection & Intervention (EHDI) (Ages 0-3 Years)
- ☐ Lead Poisoning Prevention/Healthy Homes/Safe Sleep (Ages 0-6 Years)

Referral Concerns:

Diagnosed Conditions and Other Concerns for All Referrals

- ☐ 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: _____
- ☐ Autism Spectrum Disorder
- ☐ Exposure to Toxic Substances
  - ☐ Lead *Specify*: _____ µg/dL
  - ☐ Prenatal exposure to alcohol or prescription/non-prescription drugs
    Specify: _____
- ☐ Mental/Behavioral Health Concern
  Specify: _____
- ☐ NICU *Number of 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: _____

For HM/HB Referrals

- ☐ Mother's Date of Birth:___/___/___
  - ☐ Mother 16 years or younger at birth
  - ☐ Mother 17-19 years of age at birth
- ☐ Limited prenatal care before delivery
  Month prenatal care started: _____
- ☐ Infant born preterm (>3 weeks preterm)
  Weeks preterm: _____
- ☐ Infant low birth weight (<2500 g)
  Weight at birth: _____
- ☐ Infant in NICU or other critical care nursery after birth
- ☐ Infant with birth defects or other issue
- ☐ Infant has a diagnosed medical condition requiring ongoing medical management
- ☐ Infant under the care of a specialist or clinic:
  - ☐ Medical specialist to monitor medical condition
  - ☐ Developmental specialist to monitor growth and development

For WIC Referrals

- ☐ Pregnant
- ☐ Child < 1 year of age
- ☐ Child 1-5 years of age

Comments:

Date Received by Health Services: ____/____/_____ Program Received: _____ Date Received by Program: ____/____/_____

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

Phone: Early Intervention: (601) 576-7427 or toll-free (800) 451-3903 / CYSHCN: (601) 576-7281 or toll-free (800) 844-0898

Fax: Early Intervention: (601) 576-7540 / CYSHCN: (601) 576-7296

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