NORTH CENTRAL EARLY STEPS REFERRAL FORM

Return Referral To:
UF Department of Pediatrics North Central Early Steps
Attention: Intake Service Coordinator(s)
PO Box 100296 Gainesville, FL. 32610
Fax: 352.294.8088
Phone: 352.273.8556 or 352.273.8560
http://earlysteps.pediatrics.med.ufl.edu/

SECTION 1: DEMOGRAPHICS

Child's Full Name: Date of Birth: Race:

Ethnicity: Gender: Parent(s)/Legal Guardian/Caregiver:

Primary Phone: Other Phone: E-Mail:

Street Address: City,State,& Zip

County:

SECTION 2: INSURANCE

Insurance Type: **ID:** **Parent DOB**:

SECTION 3:AGENCY/PERSON MAKING REFERRAL

Name: Agency or Facility, if any:
Phone: Fax:

SECTION 4: DEVELOPMENTAL HISTORY

Has a developmental screening been completed on this child within the past six months? YES ☐ NO ☐

If yes, please provide name of tool and results of this developmental screening:

Please check and complete one of the following (A or B):

A ☐ This child has been diagnosed with the following established condition(s) known to have a high probability of resulting in significant delays in development.

Name and Corresponding ICD-10 Code:

B ☐ There are concerns for possible delays in development in the following areas:

SECTION 5: BIRTH AND MEDICAL HISTORY

Please provide a brief history of this child's medical and /or last well baby check-up, NICU discharge summary and /or any specialty clinic note:

SECTION 6: AUTHORIZATION TO BE COMPLETED AND SIGNED BY PEDIATRICIAN, PHYSICIAN ASSISTANT OR APRN

Phone: Fax: Email:

By signing below I authorize North Central Early Steps to conduct an Interdisciplinary Psychosocial and Developmental Evaluation to determine this child's level of functioning and eligibility for the North Central Early Steps Program.

Print Name/Title:_____

Signature: _____ Date: _____