Maryland Infants and Toddlers Program Referral and Feedback Form

Please complete this form for each child you refer for early intervention. Diagnosis of a specific condition or disorder is not necessary for referral.

SECTION 1– To be completed by Physician/Health Care Provider/Referring Agency

Parent/Child Contact Information:

Child Name: _____

Date of Birth: _____/_____/_____ Child Age in Months: _____ Gender: M / F

Home Address: _____

City: _____ State: **Maryland** Zip Code: _____

Parent/Guardian: _____ Relationship to Child: _____

Primary Language: _____ Home Phone: _____ Other Phone: _____

Reason(s) for Referral to Early Intervention: *Please check all that apply.*

☐ Identified condition or diagnosis (e.g., spina bifida, Down syndrome, Birthweight <1200g): _____

☐ Suspected developmental delay or concern *(Please circle areas of concern)*:
Motor/Physical Cognitive Social/Emotional Speech/Language Behavior Other: _____

☐ Failed Standardized Developmental Screening Tool *(Please indicate screen used and attach screen results)*:
☐ Ages and Stages ☐ PEDS ☐ Other: _____

☐ At Risk/High Probability Factor *(Describe):* _____

☐ Other *(Describe):* _____

Referral Source Contact Information:

Person Making Referral: _____ Date of Referral: _____/_____/_____

Address: _____ City/State: _____ Zip: _____

Office Phone: _____ Office Fax: _____ E-mail _____

SECTION 2– To be completed by the Parent/Guardian

Parent/Guardian Consent to Release Information:

I, _____ *(print name of parent or guardian),* give my permission for my pediatric health care provider (listed above) and the Maryland Infants and Toddlers Program to share and communicate any and all pertinent information regarding my child *(print child's name)* _____.

Parent/Guardian Signature: _____ **Date:** _____/_____/_____

SECTION 3– To be completed by Local Early Intervention System (local Infants and Toddlers Program) and returned to the Referral Source (e.g., physician)

Date Referral Received: _____/_____/_____ Attempts to Contact Unsuccessful: ☐

Name of Assigned Service Coordinator: _____

Office Phone: _____ Office Fax: _____ E-mail: _____

Eligible for Early Intervention Services? ☐ Yes ☐ No

Initial Results of IFSP *(Attach IFSP Part II, Section A):*
Areas of Development to be Addressed:

☐ Cognitive ☐ Expressive Language ☐ Receptive Language ☐ Social-Emotional
☐ Adaptive/Self-Help ☐ Gross Motor ☐ Fine Motor

Initial Services to be Provided:

☐ Special Instruction ☐ Speech/Language Therapy ☐ Occupational Therapy ☐ Physical Therapy
☐ _____ ☐ _____

Form adapted from The American Academy of Pediatrics Policy Statement: Role of the Medical Home in Family-Centered Early Intervention Services: Early Intervention Referral Form. Pediatrics 2007; 120; 1153-1158.