Office Use Only
Ref. Completed Date

Helping Hands Early Intervention Program Referral Form

Department of Health
PH: 699-6962 699-6963
Ottoville Professional Building

Referring Physician or Referral Source: _____

TO BE COMPLETED BY REFERRAL SOURCE:

CHILD'S INFORMATION:
Child's Last Name:_____
MI:_____
First Name:_____
Child's DOB:_____
Gender:_____
Father:_____
Mother:_____
Village:_____
Telephone:_____

HOSPITAL BIRTH RECORD:
Admission Date: _____
APGAR:_____
Weeks Gestation:_____
Hospital Number:_____
Birth weight:_____
Head Circumference:_____
Height:_____
Plurality: _____ (i.e. single, twin)
Current Weight:_____
(if not newborn) date
Hair_____ Eye_____

REASON FOR REFERRAL:

____ **Medical Condition/Diagnosis/Syndrome Describe** *Condition:* _____
_____

____ **Developmental Delay**
Please circle and provide short description
Cognitive Development_____
Physical Development_____
Communication Development_____
Social-Emotional Development_____
Adaptive Development (Self-Help)_____

____ **At Risk for Developmental Delay** (prenatal factors/prematurity, sensory abnormalities, mental/psychosocial disorders, physical impairments, etc)
*Please describe risk concern/s:*_____
_____
_

Check if applicable
___Suspected hearing concern
___Suspected vision concern
___Suspected nutritional concern

Person completing this form:
Print Name:_____
Signature:_____
Date:_____

Comments: