First Steps

NORTHWEST INDIANA FIRST STEPS REFERRAL FORM

County: Jasper Lake Laporte Newton Porter **Date:** _____

SPOE Child ID#: _____ **45 Days:** _____

Child's Information:

Name: _____ Date of Birth: _____ ☐ Female ☐ Male

Chronological age: _____

Parent(s)/Guardian(s): _____
(Identify relationships)

Address: _____ City: _____ ZIP Code: _____
(If different from child)
Address: _____ City: _____ ZIP Code: _____

Home Phone: _____ M/D Cell: _____ M/D Work: _____ Other: _____

Referral Information:

Name: _____ Phone: _____ Relationship to the Child: _____

Secondary Referral Source: _____ Phone: _____

Reason for the referral (Please describe why the child is being referred to First Steps. Be specific about concerns.)

Doctor Information:

Name: _____ Script: ☐ Yes ☐ No

Address: _____ City: _____ ZIP Code: _____

Phone: _____ Fax: _____ Dr. Health Summary faxed: ☐ Yes ☐ No

Directions:

Dates: Intake completed on: _____ **Evaluation by:** _____ **(10 business days)**
Eligibility/IFSP Meeting scheduled for: _____ **at**
_____

Disciplines needed for evaluation: PT OT SLP DT OTHER: _____
Intake Coordinator: _____
Phone: (219) 662-7790 ext _____ **Fax: (219) 662-7510**