CHARLES COUNTY INFANTS AND TODDLERS INTAKE

Date of Referral: _____ **Reopen/Transfer:** _____ **Evaluation #1:** _____

First Name: _____ **Name of Evaluator:** _____

Middle Name: _____ **Evaluation #2:** _____

Last Name: _____ **Name of Evaluator:** _____

Address: _____ **Date of Evaluation:** _____

_____ **Place of Evaluation:** _____

City: _____ **State:** _____ **Zip:** 206_____ **Service Coordinator:** _____

Phone Number: ( ) _____ **Elementary Home School:** _____

Is the Child Adopted: Yes _____ No _____ **If Yes, Country:** _____

Is the Child Currently in Foster Care? Yes ____ No _____ **DSS Contact:** _____

Date of Birth: _____ **Gender:** Male Female **Ethnicity:** Hispanic/Latino YES/NO

Race: American Indian/Alaska Native Asian Native Hawaiian/Other Pacific Islander Black/African American White

Hospital of Birth: _____ **Gestation in Weeks:** _____ **Birth Weight:** _____

Parent/Guardian/Surrogate Information:

Relationship: _____ **First Name:**_____ **Last Name:**_____

Address: _____

City: _____ **State:** _____ **Zip:**_____ **DOB:**_____

Primary Phone # ( ) _____ **Secondary Phone #** ( ) _____

Cell Phone # ( ) _____ **Email Address:** _____

Parent/Guardian/Surrogate Information:

Relationship: _____ **First Name:**_____ **Last Name:**_____

Address: _____

City: _____ **State:** _____ **Zip:** _____ **DOB:**_____

Primary Phone # ( ) _____ **Secondary Phone #** ( ) _____

Cell Phone # ( ) _____ **Email Address:** _____

Parent/Guardian/Surrogate Information:

Relationship: _____ **First Name:** _____ **Last Name:** _____

Address: _____

City: _____ **State:** _____ **Zip:**_____ **DOB:**_____

Primary Phone # ( ) _____ **Secondary Phone #** ( ) _____

Cell Phone # ( ) _____ **Email Address:** _____

LANGUAGE

Does the Child or family speak a language other than English as their primary language? Yes No

Family's Primary language/Mode of Communication: _____ Child's:_____

Family's Secondary language/Mode of Communication: _____ Child's:_____

Is there a need for an interpreter? Yes_____ No_____

MILITARY

Is the Parent or Guardian active Military? Yes_____ No_____

If Yes, Which Branch? _____ Military Rank: _____

Does the family live in Military Housing? Yes_____ No_____

If Yes, Which Base? _____

INSURANCE

Does the Child have Medical Assistance? Yes_____ MA Number # _____ No_____

Does the family have other insurance? Yes_____ No_____

Does the Child have REM? Yes_____ No_____

Name of Pediatrician: _____

CHILD FAMILY INFORMATION

Referral Source (Who called the Single Point of Entry to make the Referral?) Circle One:

Audiologist: Is it the result of a Universal Newborn Hearing Test? Yes_____ No_____

Child/Day Care Provider Parent Foster Parent Hospital DSS LEA CCHD

Other Family Member Pediatrician Other Private Professional Other Public Agency Private Provider

Name of Person Making Referral _____ Phone # _____

ICD-9 # _____

Referral Recommended By (Who Recommended ITP to Referral Source?) Circle One:

Audiologist: Is it the result of a Universal Newborn Hearing Test? Yes_____ No_____

Child/Day Care Provider Parent Foster Parent Hospital DSS LEA CCHD

Other Family Member Pediatrician Other Private Professional Other Public Agency Private Provider

Public Awareness: (Did the Referral Source find out about the Program through a State or Local PA?)

Baltimore's Child Magazine Brochure/Promotional Item Community Fair Service Announcement Phone Book

Newborn Hearing Screening Web Site MD Public TV Newsletter Newspaper Public Awareness

None Other_____

CHILD AND FAMILY INFORMATION

Enter a statement from the person making the referral regarding the reason for the referral.

_____

_____

_____

_____

_____

_____

Select one or more of the Three Main Categories that relate to the reason for the referral. Then select one more item from the sub-categories.

DEVELOPMENT CONCERNS;

_____**Adaptive Concerns**

_____**Cognitive**

_____**Motor**

_____**Communication**

_____**Sensory-Vision**

_____**Sensory-Hearing**

_____**Social Emotional**

How was your pregnancy?

How was your delivery?

DIAGNOSED CONDITION;

_____**AIDS**

_____**Chromosomal Disorders**

Downs Syndrome

Other

_____**Congenital Infection**

_____**Drug Exposure**

_____**Epilepsy**

_____**Inborn Errors**

_____**Intraventricular Hemorrhage**

_____**Lead Poisoning 20ug/dL or greater**

_____**Neurodegenerative Disorder**

_____**Prematurity**

_____**Sensory Impairments-Visual***

_____**Sensory Impairments-Deaf***

_____**Severe Congenital Malformations**

_____**Severe Encephalopathy**

Other _____

*** If the child has Sensory Impairments, did the child pass the Universal Newborn Hearing Screening? Yes__ No__**
Vision? Yes___ No___

Environmental Factors

_____Disturbance in p/c relations

_____Inadequate/unsafe conditions

_____Maternal Age <15

_____Maternal MR

_____Other

_____Prior Involvement w/PS

Biological Factors

_____APGAR <6 @ 5 min

_____Birth weight <1200 gm

_____Congenital Infection

_____Drug Exposure

_____Exposure to toxic substance

_____Feeding Dysfunction

_____Genetic Syndrome

_____Gestational Age <34 weeks

_____Metabolic Disorder

_____Neurological Problem

_____Other

_____Significant Medical Problems

_____Small for Gestational Age

Other Factors

_____Asymptomatic Lead Intoxification

_____HIV+ Mother

_____Chromosomal

_____Congenital Infection Asymptomatic

_____Intrauterine Drug Exposure

_____Inborn Errors of Metabolism

_____Intraventricular Hemorrhage

_____Maternal Drug Abuse

_____Mild Congenital Malformation

_____Mild Insults to Brain

_____Neurodegenerative Disorder

_____Prematurity

_____Seizure Disorder

_____Sensory Impairment