GEORGIA DEPARTMENT OF PUBLIC HEALTH

Child Health Referral Form

Service Locator

Instructions: Anyone can refer a Georgia child who may qualify for Babies Can't Wait, Children 1st, Children's Medical Services, Early Hearing Detection & Intervention, or Home Visiting*. Complete this form, use the Women & Children Service Locator to find the local Child Health Referral contact, and send it to them. *Home Visiting is not available in all counties.

REFERRAL CONTACT INFORMATION

You may skip this section if parent or guardian is completing the form.

Referring Person/Practice:	**Phone:**	**Fax:**	**Email:**

Is the parent or guardian aware of this referral? ☐ No ☐ Yes

CHILD INFORMATION

Child's First Name:	**Child's Last Name:**	**Child's Date of Birth:**	**Child's Sex:** ☐ Male ☐ Female

Birth Mother's First and Last Name:	**Birth Mother's Date of Birth (If known):**

Child's Race (Select all that apply):	**Child's Ethnicity:**	**Child's Insurance (If known):**
☐ American Indian or Alaska Native ☐ White ☐ Asian ☐ Hawaiian or Other Pacific Islander ☐ Black or African American ☐ Other: _____ ☐ Prefer not to answer	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer ☐ Other:	☐ Medicaid/PeachCare for Kids ☐ Commercial/Private ☐ Unknown ☐ None Insurance Policy # (if known):

Child's Primary Medical Provider Name and Phone Number (If known):

PARENT/GUARDIAN CONTACT INFORMATION

Guardian First and Last Name:	**Relationship to Child:**	**Phone Number:**	**Alternative Phone Number:**

Email:	**Street Address:**	**City:**

State:	**Zip Code:**	**County (If known):**	**Primary Language:** ☐ English ☐ Spanish ☐ Other _____	**Interpreter Needed:** ☐ No ☐ Yes

DFCS Case Worker Name and Phone Number (If applicable):

REASON(S) FOR REFERRAL (SELECT ALL THAT APPLY)

☐ **Confirmed diagnosis.** Child has a diagnosed condition that impacts development and/or is a chronic medical condition.

Diagnosis and ICD-10 Code (*Attach diagnostic report*):

View eligible codes in the Child Health Conditions Database.

☐ **Suspected developmental delay or diagnosis.** Child may have a developmental delay. Screening or evaluation is needed.

Select all that apply:
☐ Motor/Physical
☐ Social/Emotional
☐ Speech/Communication
☐ Behavior/Adaptive
☐ Hearing

Has child received a recent screening?
☐ No ☐ Yes (Attach results)

☐ **At risk for developmental delay.** Child has medical, social, or environmental risk factors and may benefit from screening.

Select all that apply:
☐ Prematurity and/or low birth weight
☐ Prenatal substance exposures
☐ Child safety concerns (e.g. abuse, neglect, family violence)
☐ Unstable household environment
☐ Other:

Comments:

Office Use Only: Date Routed: _____ Program(s): ☐ BCW ☐ C1st ☐ CMS ☐ EHDI ☐ HV ☐ Other: _____
SendSS #: _____