



**HEALTH SUMMARY**

NAME OF CHILD	DATE OF BIRTH	DATE COMPLETED
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**INSTRUCTIONS**

Current medical information is important to assist in eligibility determination for a child referred to First Steps and, if the child is found eligible, planning for First Steps services.

Complete this form with information about the child referred to First Steps and return it as soon as possible to the First Steps System Point of Entry (SPOE) office. The SPOE contact information is included below.

**BIRTH HISTORY**

BIRTH WEIGHT (GRAMS)	GESTATIONAL AGE (WEEKS)
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**HEALTH STATUS**

DIAGNOSIS	ICD-9 CODE	ICD-10 CODE
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HOSPITALIZATIONS/SURGERIES

CONCERNS/COMMENTS

**DEVELOPMENTAL STATUS**

VISION STATUS	DATE SCREENED/TESTED	RESULTS
HEARING STATUS	DATE SCREENED/TESTED	RESULTS
DEVELOPMENTAL STATUS	DATE SCREENED/TESTED	RESULTS

Developmental Screening Attached       Additional Information Attached

CONCERNS/COMMENTS

**PHYSICIAN INFORMATION**

PRINTED NAME OF PRIMARY PHYSICIAN	PHONE NUMBER
PRIMARY PHYSICIAN SIGNATURE	FAX NUMBER
PERSON COMPLETING THIS FORM	DATE COMPLETED

**SPOE CONTACT INFORMATION**

SPOE AGENCY NAME AND ADDRESS	FAX NUMBER
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