



MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF SPECIAL EDUCATION - FIRST STEPS PROGRAM



NEONATAL INTENSIVE CARE UNIT (NICU) REFERRAL FORM

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|---|---------------|--|--|--|---|
| NAME OF CHILD* | | DATE OF BIRTH* | GENDER* Male <input type="checkbox"/> Female <input type="checkbox"/> Ambiguous <input type="checkbox"/> | | DATE COMPLETED |
| INSTRUCTIONS | | | | | |
| To refer a newborn to the First Steps program, NICU staff may complete this form or submit a referral online at: www.mofirststeps.com . To submit a referral using this form, an asterisk (*) indicates required information. Return the completed form to the System Point of Entry (SPOE) serving the county in which the child resides. Contact information for the SPOE can be found at: http://dese.mo.gov/special-education/first-steps . | | | | | |
| CHILD INFORMATION | | | | | |
| BIRTH WEIGHT (GRAMS)* | | GESTATIONAL AGE (WEEKS)* | | Is the child currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> APGAR of 6 or less at 5 minutes | | <input type="checkbox"/> Intraventricular hemorrhage (Grade II, III or IV) | | <input type="checkbox"/> Any Positive Pressure Ventilation > than 48 hours, including ventilator or oscillator | |
| DIAGNOSIS | | ICD-9 CODE | ICD-10 CODE | COMMENTS | |
| PRIMARY CARE PHYSICIAN | | PRIMARY CARE PHYSICIAN PHONE NUMBER | | | |
| PARENT/ GUARDIAN INFORMATION | | | | | |
| PARENT/GUARDIAN NAME* | | | RELATIONSHIP TO CHILD * | | PRIMARY LANGUAGE* |
| ADDRESS/CITY/STATE/ZIP* | | | PHONE NUMBER* | | ALTERNATE PHONE NUMBER |
| COUNTY* | EMAIL ADDRESS | | Has the parent been informed of this referral?* <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| REFERRAL SOURCE INFORMATION | | | | | |
| REFERRING HOSPITAL* | | | | HOSPITAL PHONE NUMBER* | |
| PRINTED NAME OF REFERRING PHYSICIAN* | | | REFERRING PHYSICIAN SIGNATURE* | | DISCHARGE SUMMARY ATTACHED? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| PERSON COMPLETING THIS FORM* | | | PHONE NUMBER* | | EMAIL ADDRESS |
| SPOE USE ONLY | | | | | |
| REFERRAL DATE | | | REFERRAL RECEIVED VIA <input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> Phone | | |
| INTAKE COORDINATOR NAME | | | DATE ASSIGNED | | |

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