



**PHYSICIAN INFORMED CLINICAL OPINION  
AND IMPACT STATEMENT**

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

First Steps is Missouri's early intervention system for infants and toddlers, birth to age three, who have a diagnosed condition associated with developmental disabilities, or a high probability of a developmental delay or disability. For conditions not listed in the First Steps eligibility criteria, a physician must provide documentation of the diagnosed condition and potential impact in at least one developmental area.

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.

**PHYSICIAN USE ONLY**

DIAGNOSED CONDITION	ICD-9 CODE	ICD-10 CODE
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There is potential for this diagnosed condition to impact the child's development.  No  Yes

If yes, indicate the potential impact of the condition in **each** developmental area below:

COGNITIVE / LEARNING, CHECK ONE: <input type="checkbox"/> No concerns <input type="checkbox"/> At risk <input type="checkbox"/> High probability of disability	IF HIGH PROBABILITY, DESCRIBE:
PHYSICAL / VISION / HEARING, CHECK ONE: <input type="checkbox"/> No concerns <input type="checkbox"/> At risk <input type="checkbox"/> High probability of disability	IF HIGH PROBABILITY, DESCRIBE:
COMMUNICATION / NONVERBAL LANGUAGE, CHECK ONE: <input type="checkbox"/> No concerns <input type="checkbox"/> At risk <input type="checkbox"/> High probability of disability	IF HIGH PROBABILITY, DESCRIBE:
SOCIAL / EMOTIONAL / BEHAVIORS, CHECK ONE: <input type="checkbox"/> No concerns <input type="checkbox"/> At risk <input type="checkbox"/> High probability of disability	IF HIGH PROBABILITY, DESCRIBE:
ADAPTIVE / SELF HELP, CHECK ONE: <input type="checkbox"/> No concerns <input type="checkbox"/> At risk <input type="checkbox"/> High probability of disability	IF HIGH PROBABILITY, DESCRIBE:

PRINTED NAME OF PHYSICIAN	SPECIALITY
PHYSICIAN ADDRESS	PHYSICIAN PHONE NUMBER
PHYSICIAN SIGNATURE	DATE OF SIGNATURE

**SPOE CONTACT INFORMATION**

SPOE AGENCY NAME AND ADDRESS	FAX NUMBER
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