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

NEONATAL INTENSIVE CARE UNIT (NICU) REFERRAL FORM

NAME OF CHILD*	DATE OF BIRTH*	GENDER* Male ☐ Female ☐ Ambiguous ☐	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? ☐ Yes ☐ No	
☐ APGAR of 6 or less at 5 minutes	☐ Intraventricular hemorrage (Grade II, III or IV)	☐ Any Positive Pressure Ventilation > than 48 hours, including ventilator or oscillator	☐ Resuscitation/code-event requiring chest compressions

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?* ☐ Yes ☐ No	

REFERRAL SOURCE INFORMATION

REFERRING HOSPITAL*		HOSPITAL PHONE NUMBER*
PRINTED NAME OF REFERRING PHYSICIAN*	REFERRING PHYSICIAN SIGNATURE*	DISCHARGE SUMMARY ATTACHED? ☐ Yes ☐ No
PERSON COMPLETING THIS FORM*	PHONE NUMBER*	EMAIL ADDRESS

SPOE USE ONLY

REFERRAL DATE	REFERRAL RECEIVED VIA ☐Mail ☐Fax ☐Phone
INTAKE COORDINATOR NAME	DATE ASSIGNED