MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD - EARLY INTERVENTION

REFERRAL FORM

NAME OF CHILD*	DATE OF BIRTH*	GENDER* Male ☐ Female ☐ Ambiguous ☐	DATE COMPLETED

INSTRUCTIONS

To refer a child to the First Steps program, 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: https://dese.mo.gov/childhood/early-intervention/first-steps

CHILD INFORMATION

REASON FOR REFERRAL*		
DOES THE CHILD HAVE A DIAGNOSIS? No ☐ Yes ☐ If yes, explain:	ICD-9 CODE	ICD-10 CODE
COMMENTS		

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

NAME*		AGENCY	
ADDRESS/CITY/STATE/ZIP		PHONE NUMBER*	FAX NUMBER
FOR REFERRALS FROM PARENTS ONLY: HOW DID YOU FIND OUT ABOUT FIRST STEPS?*			

SPOE USE ONLY

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