Northeastern early steps

UF College of Medicine – Jacksonville UNIVERSITY of FLORIDA

910 North Jefferson - Jacksonville, Florida- 32209 Phone: 904-427-7600 Fax: 904-798-4544

Referral to Northeastern Early Steps Program

For developmental screening, evaluation and treatment as needed

Referring by: _____Organization/Clinic Name:_____

Address_____Phone#_____Fax#_____

Date of Referral: _____ Referral To: _____Early Steps ____Pediatric Hearing Program

Reason for Referral/ Diagnosis: Including ICD 10 Codes **Yes/No** At- Risk?(see list) **Yes/No** Est. Condition (see list)

Well Vist/Developmental Screening Scores/Diagnosis Documentation Attached YES / NO

Referred by: (MD/RN/ARNP/LCSW/LMHC Signature):_____

MUST BE Signed by Licensed Healthcare Provider

Child's Name: _____ DOB: _____ Sex: **M** or **F**

Caregiver's Name: _____ Relationship: _____

Primary Contact(phone/email)_____

Secondary Contact (phone/email)_____

Address:_____**City**_____

State: _____ZIP Code:_____

Primay Care Provider/Pediatrician:_____**Clinic Name:**_____

"I _____ give permission for _____

(Legal guardian's printed name) ***(Referring agency***

and Northeastern Early Steps to exchange medical, developmental and educational information regarding

_____ _____ _____

Child's Name ***Legal Guardian's signature*** ***Date***

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FAX to: 904-798-4544 or Call 904-427-7600 option #2

Notice: ***"This communication contains confidential information. Re-disclosure of any information within this document without consent of the client is prohibited by law. If you feel you have received this document in error, please notify the sender."***