



PUBLIC HEALTH (BCPH)
Children with Special Needs Program Referral Form
Telephone: (303) 678-6064
Fax: (303) 678-6125

Child's Name _____	Date of Birth _____	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Current Address _____	Telephone _____	
City _____	Place of Birth _____	
Zip Code _____	Primary Care Provider _____	
Mother _____	Father _____	
HMO/Insurance _____	Medicaid # _____	SS# _____
Primary Language in Home _____	Monolingual? Yes <input type="checkbox"/> No <input type="checkbox"/>	Race/Ethnicity _____

Reason for Referral	Part C Eligible
<input type="checkbox"/> First time mother	<input type="checkbox"/> Chromosomal syndromes 655.1/758
<input type="checkbox"/> Premature birth (less than 28 weeks gestation) 765.0	<input type="checkbox"/> Congenital conditions
<input type="checkbox"/> Premature birth (28-36 weeks gestation) 765.10	<input type="checkbox"/> CNS malformation 742.9 <input type="checkbox"/> FAS 760.71
<input type="checkbox"/> Low birth weight (less than 3 lb 5oz [1500 gms]) 765.5 Birth weight: _____	<input type="checkbox"/> Brain abnormality
<input type="checkbox"/> Low Apgar <u> </u> / <u> </u> / <u> </u>	<input type="checkbox"/> Sensory impairments: <input type="checkbox"/> Vision 369.9
<input type="checkbox"/> Born with congenital anomaly (identify) 759.9	<input type="checkbox"/> Metabolic disorders 277.8
<input type="checkbox"/> No prenatal care V23.7	<input type="checkbox"/> Pre-and perinatal condition: <input type="checkbox"/> TORCH 759.7 <input type="checkbox"/> IVH Gr 3 or 4 772.2
<input type="checkbox"/> Intrauterine drug exposure 760.70	<input type="checkbox"/> Teratogens 760.79 <input type="checkbox"/> HIV Pos V01.7
<input type="checkbox"/> Moc 15 years or less at time of birth 659.8	<input type="checkbox"/> Seizures 779.0 <input type="checkbox"/> Meningitis 322.9
<input type="checkbox"/> Failed newborn hearing Right <input type="checkbox"/> Left <input type="checkbox"/>	<input type="checkbox"/> Positive Toxicology Screen Drug Type _____
Number of re-screens <input type="checkbox"/> ABR <input type="checkbox"/> OAE <input type="checkbox"/> Both <input type="checkbox"/>	<input type="checkbox"/> Apgar <5 after 5 minutes
	<input type="checkbox"/> Birth weight-1200 gms or less (2 lb 11oz) 765.4
	<input type="checkbox"/> Medical problems that may result in developmental delays
	<input type="checkbox"/> Postnatal acquired problems (i.e. severe attachment problems)
	<input type="checkbox"/> Significant development delays/per eval. 783.4

Comments:
 Other agencies/programs involved with your family- **BCPH:** CIP GENESIS Nurse-Family Partnership WIC
Other: Part C/Kids Connection Imagine!/Community Center Board

REFERRED BY: _____
 Signature _____ Agency _____
 Telephone _____ Date _____

Verbal permission obtained from parent to forward a copy of child's discharge plan to Public Health _____
 Initials _____ Date _____
 Verbal permission obtained from parent to refer to Part C Programs. _____
 Initials _____ Date _____

Office Use Only: _____