Child Health Referral Form

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Service Locator

Instructions: Anyone can refer a Georgia child who may qualify for Babies Can't Wait, Children 1st, Children's Medical Services, Early Hearing Detection & Intervention, or Home Visiting*. Complete this form, use the Women & Children Service Locator to find the local Child Health Referral contact, and send it to them. *Home Visiting is not available in all counties.

REFERRAL CONTACT INFORMATION
You may skip this section if parent or guardian is completing the form.

Referring Person/Practice:	Phone:	Fax:	Email:

Is the parent or guardian aware of this referral? ☐ No ☐ Yes

CHILD INFORMATION

Child's First Name:	Child's Last Name:	Child's Date of Birth:	Child's Sex: ☐ Male ☐ Female

Birth Mother's First and Last Name: | **Birth Mother's Date of Birth (If known):**

Child's Race (Select all that apply):
☐ American Indian or Alaska Native
☐ White
☐ Asian
☐ Hawaiian or Other Pacific Islander
☐ Black or African American
☐ Other: _____
☐ Prefer not to answer

Child's Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Prefer not to answer
☐ Other:

Child's Insurance (If known):
☐ Medicaid/PeachCare for Kids
☐ Commercial/Private
☐ Unknown   ☐ None
Insurance Policy # (if known):

Child's Primary Medical Provider Name and Phone Number (If known):

PARENT/GUARDIAN CONTACT INFORMATION

Guardian First and Last Name:	Relationship to Child:	Phone Number:	Alternative Phone Number:
Email:	Street Address:		City:

State: **GA**	Zip Code:	County (If known):	Primary Language: ☐ English ☐ Spanish ☐ Other _____	Interpreter Needed: ☐ No ☐ Yes

DFCS Case Worker Name and Phone Number (If applicable):

REASON(S) FOR REFERRAL (SELECT ALL THAT APPLY)

☐ **Confirmed diagnosis.** Child has a diagnosed condition that impacts development and/or is a chronic medical condition.

Diagnosis and ICD-10 Code (*Attach diagnostic report*):

View eligible codes in the Child Health Conditions Database.

☐ **Suspected developmental delay or diagnosis.** Child may have a developmental delay. Screening or evaluation is needed.

Select all that apply:
☐ Motor/Physical
☐ Social/Emotional
☐ Speech/Communication
☐ Behavior/Adaptive
☐ Hearing

Has child received a recent screening?
☐ No   ☐ Yes (Attach results)

☐ **At risk for developmental delay.** Child has medical, social, or environmental risk factors and may benefit from screening.

Select all that apply:
☐ Prematurity and/or low birth weight
☐ Prenatal substance exposures
☐ Child safety concerns (e.g. abuse, neglect, family violence)
☐ Unstable household environment
☐ Other:

Comments: