



**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.

<b>Referring Person/Practice:</b>	<b>Phone:</b>	<b>Fax:</b>	<b>Email:</b>
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Is the parent or guardian aware of this referral?  No  Yes

### CHILD INFORMATION

<b>Child's First Name:</b>	<b>Child's Last Name:</b>	<b>Child's Date of Birth:</b>	<b>Child's Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
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<b>Birth Mother's First and Last Name:</b>	<b>Birth Mother's Date of Birth (If known):</b>
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<b>Child's Race (Select all that apply):</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian or Other Pacific Islander	<input type="checkbox"/> Black or African American <input type="checkbox"/> Other: _____ <input type="checkbox"/> Prefer not to answer	<b>Child's Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Other: _____	<b>Child's Insurance (If known):</b> <input type="checkbox"/> Medicaid/PeachCare for Kids <input type="checkbox"/> Commercial/Private <input type="checkbox"/> Unknown <input type="checkbox"/> None Insurance Policy # (if known): _____
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**Child's Primary Medical Provider Name and Phone Number (If known):**

### PARENT/GUARDIAN CONTACT INFORMATION


<b>Guardian First and Last Name:</b>	<b>Relationship to Child:</b>	<b>Phone Number:</b>	<b>Alternative Phone Number:</b>
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<b>Email:</b>	<b>Street Address:</b>	<b>City:</b>
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<b>State:</b>	<b>Zip Code:</b>	<b>County (If known):</b>	<b>Primary Language:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____	<b>Interpreter Needed:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes
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**DFCS Case Worker Name and Phone Number (If applicable):**

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

<input type="checkbox"/> <b>Confirmed diagnosis.</b> Child has a diagnosed condition that impacts development and/or is a chronic medical condition.  Diagnosis and ICD-10 Code ( <i>Attach diagnostic report</i> ):   View eligible codes in the <a href="#">Child Health Conditions Database</a> .	<input type="checkbox"/> <b>Suspected developmental delay or diagnosis.</b> Child may have a developmental delay. Screening or evaluation is needed.  <i>Select all that apply:</i> <input type="checkbox"/> Motor/Physical <input type="checkbox"/> Social/Emotional <input type="checkbox"/> Speech/Communication <input type="checkbox"/> Behavior/Adaptive <input type="checkbox"/> Hearing  <i>Has child received a recent screening?</i> <input type="checkbox"/> No <input type="checkbox"/> Yes (Attach results)	<input type="checkbox"/> <b>At risk for developmental delay.</b> Child has medical, social, or environmental risk factors and may benefit from screening.  <i>Select all that apply:</i> <input type="checkbox"/> Prematurity and/or low birth weight <input type="checkbox"/> Prenatal substance exposures <input type="checkbox"/> Child safety concerns (e.g. abuse, neglect, family violence) <input type="checkbox"/> Unstable household environment <input type="checkbox"/> Other: _____
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**Comments:**