Physician Referral and Consent for First Steps

Contact the SPOE office at: (812) 231-8337 or 1-877-860-0413 ***Today's Date:*** _____

Please PRINT. Please complete as much information as possible. * Items are *required* information.

*Child's Name: _____ *Date of Birth: _____

Child's Sex: Male Female Child's Birth Weight: _____ Gestational Age: _____ Apgar: _____

*Parent's Name(s): _____

*Address: _____

City: _____ Zip: _____ County of Residence: _____

*Phone #: _(_____)_____ Alternate Phone #: _(_____)_____

*Primary Medical Provider: _____ Phone: (____)_____

*Name of Person Making Referral: _____ Phone: (____)_____

***Please indicate your concern:**

___ 1) Diagnosed Medical Condition (please specify) _____
ICD-9 Code _____

___ 2) Failed Newborn Screening (hearing, etc.) _____

___ 3) Suspected Developmental Delay (15% or more) in one or more of the following:
___ Gross or Fine Motor ___ Feeding Skills ___ Cognitive
___ Receptive or Expressive Language ___Social / Emotional
___ Other (please specify) _____

___ 4) Biological Risk for Developmental Delay:
___ Limited Prenatal Care ___ Maternal prenatal substance abuse
___ Small for gestational age (SGA) ___ Severe perinatal complications
___ Severe hypoxia ___ Low birth weight
___ Severe prenatal complications ___ Severe post natal complications

***Has this referral been discussed with the family? ___ Yes ___ No**

Additional Comments: _____

I authorize the following evaluation / treatment, as indicated:

___ Physical Therapy ___ Speech Therapy ___ Nutrition
___ Occupational Therapy ___ Psychological Services ___ Hearing
___ Vision ___ Developmental Therapy

___ Other (please specify): _____

_____ _____
*Physician's Signature Date

_____ _____
*Physician's Name – Please print *Phone Number

FAX THIS FORM TO THE SPOE OFFICE AT 1-866-395-6034

SPOE Office use only: Date Rec'd: _____ Date CRO entered: _____

IC: _____ Day 45: _____ Entered by: _____