PRINCE GEORGE'S COUNTY
INFANTS AND TODDLERS PROGRAM

INTERAGENCY INTAKE FORM

Send By Email

REFERRAL TYPE

☐ New (45 days)
☐ Re-Referral (45 days)
☐ Transfer
Jurisdiction: _____

DIAGNOSED CONDITION

☐ Yes ☐ No

CHILD ID _____

RECORDED BY_____ **DATE**_____ **IMPLEMENTATION DATE** _____

MANAGER AGENCY: **ECC:**

Does the child reside in Prince George's County? ☐ Yes ☐ No

Child's Name_____ Male Female Date of Birth_____
First MI Last

Age _____

Child's Address_____

Race/Nationality_____

_____

Phone_____

Name of Apt. Complex or
Housing development_____

REASON FOR REFERRAL

REASON FOR REFERRAL:

Does the pediatrician share these concerns? ◉ Yes ○ No

REFERRAL INFORMATION

Referral Source _____
(Who is calling to make referral?)

Recommended by_____
(Who recommended ITP to **Referral Source?**)

Public Awareness _____
(Did the **Referral Source** learn about ITP from a State and/or Local PA Activity?)

Phone _____

Is parent aware this referral is being made? ☐ Yes ☐ No

FAMILY INFORMATION

Mother/Guardian/Foster_____

Father/Guardian/Foster_____

Cell Phone_____

Cell Phone_____

Work _____

Work Phone _____

Email:_____

Child's Name: _____ **DOB:** _____

Is the child in foster care? ☐ Yes ☐ No Social worker/Telephone _____

What language is spoken in the home? _____ Interpreter needed? ☐ Yes ☐ No

Back-up contact Name/Relationship_____ Phone_____

Is the parent active in the military service? ☐ Yes ☐ No Branch _____

Does the family live in military housing/base? ☐ Yes ☐ No Housing Dev./Base_____

INSURANCE INFORMATION

Medical Assistance Number (11 digits) _____ MCO_____

Private Insurance Carrier _____ Social Security Number _____

REM (Rare and Expensive Medical) ☐ Yes ☐ No Model Waiver ☐ Yes ☐ No
SSI (Supplemental Security Income) ☐ Yes ☐ No WIC (Women Infant Children) ☐ Yes ☐ No

REM Case Worker/Agency _____ Phone _____

CPS Social Worker _____ Phone _____

MEDICAL INFORMATION

Primary Care Provider _____ Phone_____

Hospital of Birth _____

Available Reports (check all that apply)

☐ Birth Discharge Summary
☐ Copy of Immunization Record
☐ Developmental Evaluation Report
☐ Audiology
☐ Vision
☐ Other _____

Services being provided (currently)

☐ Physical Therapy
☐ Occupational Therapy
☐ Speech & Language Therapy
☐ Nursing Services
☐ Special Instruction
☐ Other _____

COMMENTS:

Reminders: You must send medical reports and/or court documents along with this referral to the following fax number: 301-856-9459

Send By Email