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:

1. Updated Immunization Record.
2. If over 30 months: copy of birth certificate, deed or lease.
3. Have copies of discharge summary and/or evaluation reports when Service Coordinator arrives for first home visit.

Child's name: Date of birth:

PRINCE GEORGE'S COUNTY INFANTS AND TODDLERS PROGRAM
HEALTH HISTORY

PREGNANCY and BIRTH HISTORY

Was your child born prematurely (less than 38 wks)? ☐ yes ☐ no

If so, how early was your child born? _____ (weeks)

Were there any problems during pregnancy? ☐ yes ☐ no

What problems? _____

Did you have a C-section? If so, why:

At which hospital was your baby born?

What was your baby's birth weight? (Pounds and ounces)

Were there any problems at or soon after birth? ☐ yes ☐ no

If YES, please check:

☐ Breathing	☐ Apnea monitor	☐ Infections
☐ Oxygen needed	☐ Convulsions/seizures	☐ Resistant to antibiotics
☐ Ventilator needed	☐ Tube feeding needed	☐ Other
☐ BPD	☐ NEC	

Did he/she pass the newborn hearing screen? ☐ yes ☐ no ☐ not sure

Did he/she pass the newborn vision screen? ☐ yes ☐ no ☐ not sure

Were any follow-up hearing tests recommended? ☐ yes ☐ no ☐ not sure

Were any follow-up vision tests recommended? ☐ yes ☐ no ☐ not sure

How long was your baby in the hospital? Explain why if longer than 3 days.

Did he/she get transferred to any other hospital? ☐ yes ☐ no ☐ not sure

Describe:

Child's name: Date of birth:

CURRENT MEDICAL ISSUES

Are your child's immunizations up to date? ☐ yes ☐ no ☐ not sure

Has any medical provider informed you that your child has any health conditions? (such as asthma, sickle cell, metabolic or genetic problems) ☐ yes ☐ no ☐ not sure

Also, list specialists, location, and date last seen:

Does your child attend a NICU follow-up clinic or a developmental clinic?

☐ yes ☐ no ☐ not sure

Has he/she been hospitalized since birth? If so, please explain why, which hospital, and dates.

☐ yes ☐ no ☐ not sure

Describe:

Has your child been tested for lead? ☐ yes ☐ no ☐ not sure

If YES, do you know the level? ☐ **Within Normal Limits** **Other:**

Do you have any concerns about:

- Your child's vision? ☐ yes ☐ no
- Your child's hearing? ☐ yes ☐ no
- A previous head injury? ☐ yes ☐ no
- A lot of ear infections, IF YES ☐ yes ☐ no
  How many ear infections? _____

Is your child taking any medications? ☐ yes ☐ no

DEVELOPMENTAL HISTORY

Have you ever noted anything unusual or slow about your child's development or behavior? ☐ yes ☐ no

Child's name: Date of birth:

Do you remember the age when your child learned to:

MOTOR		LANGUAGE	
Roll over	_____ (mo)	Social smile	_____(mo)
Sit without support	_____(mo)	Babble (dadada)	_____(mo)
Pull to stand	_____(mo)	Peek-a-boo*	_____(mo)
Walk alone	_____(mo)	Single word	_____(mo)
		Say 4-6 words	_____(mo)
		Say 2 words together	_____(mo)

Current words: (attach word list as appropriate)

List:

Any concerns that your child has lost any skills? ☐yes ☐no

Describe:

If YES, describe at what age the loss of skills occurred: _____ (months)

FAMILY HISTORY

Who resides in the household? Age (optional)

_____ _____
_____ _____
_____ _____
_____ _____

Is there any family history of the following conditions:
If YES, state relationship:

☐Mental retardation _____
☐Autism _____
☐Pervasive Developmental Disorder _____
☐Hearing loss _____
☐Speech/language problems _____
☐Learning problems _____
☐Mental health problems _____
☐Seizures _____
☐Vision loss _____

Key:
m=mother/f=father/s=sibling/a=aunt/u=uncle
c=cousin/g=grandparent/o=other

SOCIAL/RELATING (complete if child is 12 months and older)

Does your child take an interest in other children? ☐yes ☐no
Does your child ever use his/her index finger to point to indicate to someone else that something is interesting? ☐yes ☐no

Or any other social games you play with your child, such as: patty cake, so big, blowing kisses, clapping, making "tortillas," etc.

Child's name: Date of birth:

Does your child ever bring objects over to you to show you something?	☐ yes	☐ no
Does your child ever imitate you? (e.g. you make a face, will your child imitate it)	☐ yes	☐ no
Does your child respond to his name when you call?	☐ yes	☐ no
If you point at a toy across the room, does your child look at it?	☐ yes	☐ no

What is the child's daily routine like? Does he/she have the chance to be around peers?

Comments/Notes

Information obtained from: _____

Form completed by: _____

Date form completed: _____

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