



Child Health Referral Form

Date Completed: _____



Service Locator

Instructions: Anyone can refer a Georgia child who may qualify for Babies Can't Wait (0-3rd birthday), Children 1st (0-5th birthday), Children's Medical Services (0-21st birthday), Early Hearing Detection & Intervention (0-5th birthday), or MIECHV*. Complete this form, scan the QR code, or visit [Women & Children Service Locator](#) to find the local Child Health Referral contact, and send the form to them. *MIECHV 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

☐ Black or African

☐ White

American

☐ Asian

☐ Other: _____

☐ Hawaiian or Other Pacific Islander

☐ 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:

Alternate Phone Number:

Email:

Street Address:

City:

State:

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 conditions 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:

Office Use Only:

Date Child Health Referral Received: _____ SendSS #: _____

Date Routed: _____ Program(s): ☐ BCW ☐ C1st ☐ CMS ☐ EHD ☐ MIECHV ☐ DPH HV ☐ Other: _____