PLEASE SEND FORMS TO: Stars Infant Program - FAX: (866)501-8318 Phone: (844)700-9889
EMAIL: sarcintake@starsinfantprogram.com

S.A.R.C USE ONLY
Referral Date: _____
14 days: _____
45 days: _____

DEMOGRAPHIC INFORMATION

Early Start Intake form (age 0-2.11 years)

Referred by:_____Phone(___)_____Fax(___)_____
Reason for Referral: _____
_____
_____

Child's Name: _____ DOB:_____Age: _____
Social Security #: _____/_____/_____ Sex: ☐ Male ☐ Female
Language at home: _____ School District: _____
Lives with: ☐ Mother ☐ Father ☐ Outside of Home

Mother's Name: _____ Phone(____)_____
Address: _____Apt#_____City_____Zip Code_____
Language at home: _____ Mother's DOB: _____

Father's Name: _____ Phone(____)_____
Address: _____Apt#_____City_____Zip Code_____
Language at home: _____ Father's DOB: _____

IF CHILD DOES NOT RESIDE IN HOME OF PARENTS:
Name of primary care giver: _____Phone(___)_____
Address: _____Language: _____
Placement agency/worker _____Date of current placement: _____
Who can sign consent for child?_____ ☐Foster ☐Other _____

Primary Physician Name: _____ Phone (____)_____
Address: _____City_____Zip Code_____
Other Physician: _____Phone(____)_____
Address: _____

INSURANCE/FINANCIAL INFORMATION:
Medical #: _____Private Health Insurance Co. _____

MEDICAL INFORMATION

Child's Name _____

MUST MEET ONE OF THE FIVE CATEGORIES

Significant Developmental Delay: Please describe (DO NOT LIST ONLY SPEECH AND LANGUAGE DELAY)

☐ Communication (Specify) _____

_____

_____

Has child had a hearing evaluation? ☐ Yes ☐ No If yes, please send. If no, please rule out hearing loss.

☐ Physical Motor _____

_____

☐ Adaptive/Self-Help _____

_____

☐ Social-Emotional _____

_____

☐ Cognitive_____

_____

HIGH RISK: check at least two:

☐ Prematurity of less than 32 weeks and/or low birth weight of less than 1500 grams

☐ Ventilation for 48 hours or longer ☐ Small for gestational age ☐ A five minute Apgar Score of 0 to 5

☐ Severe and persistent metabolic abnormality, including but not limited to hypoglycemia, acidemia and hyperbilirubinemia ☐Neonatal seizures or nonfebrile seizures ☐Central nervous system lesion or abnormality

☐ Central nervous system infection ☐Biomedical insult including, but not limited to, injury, accident or illness

☐ Multiple congenital abnormalities or genetic disorders ☐ Prenatal exposure to known teratogens

☐ Clinically significant failure to thrive ☐ Persistent hypotonia or hypertonia

☐ Prenatal substance exposure, positive infant neonatal toxicology screen or symptomatic neonatal toxicity or withdrawal

☐ The parent of the infant or toddler is a person with a developmental disability

LIST SIGNIFICANT HEALTH PROBLEMS/DX: (including seizures, history of ear infections, feeding problems)

_____

_____

MEDICATIONS/EQUIPMENT:_____

_____

BIRTH INFORMATION:

Length of Pregnancy: _____ **Birth Weight**: _____

ADDITIONAL COMMENTS/SIGNIFICANT SOCIAL FACTORS: _____

_____

_____

PLEASE SEND MOST RECENT WELL CHILD EXAM AND ANY DEVELOPMENTAL SCREENING (ASQ, M-CHAT)