



EARLY STEPS REFERRAL CHECKLIST

Clear

Instructions: If a child has any condition or concern that has a **high probability of being associated with a developmental delay or poor behavioral outcome**, the child should be referred for early intervention services, Early Steps. This checklist identifies condition(s) or specific area of concern(s) that may make an **infant or toddler, birth to 36 months of age**, eligible for early intervention services. **Please check all applicable items.**

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

Parent/Caregiver Name: _____ Telephone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

CERTIFIED CONDITION	☐ Hearing Impairment ☐ Visual Impairment/blind ☐ Chromosome anomaly (<i>such as Down's Syndrome</i>) ☐ Neurological condition (<i>such as Cerebral Palsy</i>) ☐ Seizure Disorder (<i>such as epilepsy</i>) ☐ Physical abnormality/abnormal movement ☐ Other (specify): _____
DEVELOPMENTAL DELAYS	☐ 3 months and child does not watch moving objects or respond to sounds ☐ 6 months and unable to roll over ☐ 9 months and unable to sit alone ☐ 12 months and unable to crawl (<i>or crawls with great difficulty</i>) ☐ 15 months unable to stand alone ☐ 15 months and unable to hold a cup ☐ 18 months and has no speech or only babbles ☐ 18 months and unable to walk ☐ 24 months and unable to use objects like crayons or spoons ☐ 24 months and does not engage in play or social interaction ☐ Other (specify): _____
OTHER CONCERNS	☐ Feeding/Eating difficulty ☐ Shaken baby/head injury ☐ Chronic illness ☐ Child in hospital or recent hospitalization ☐ Child extremely underweight or appears malnourished ☐ Lack of eye contact or lack of interest in interaction with parent/caregiver ☐ Substance abuse exposure or withdrawal symptoms (prenatal drug exposure or Fetal Alcohol Syndrome) ☐ Other (specify): _____