



First Steps Point of Entry
c/o LifeSkills, Inc.
P.O. Box 6499
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(270) 901-5749 or (800) 643-6233
Fax (270) 746-0729

Referral Form

Your name (required): _____ Date: _____

Relationship to child: Parent/Guardian: _____ Other: _____

Is the family aware you are making the referral? Yes _____ No _____

Agency Name: _____ Phone: _____

Your Address: _____ Fax: _____

Your e-mail: _____

Child's Name: _____ DOB: _____
Hospital of birth (if known): _____ Gestational Age: _____ mos.
Child resides with: Parent/Legal Guardian/Foster Family Name: _____
Address: _____
Home Phone: _____ Cell Phone: _____
If family has no phone, contact person: _____
Relationship to child: _____ Phone: _____
Primary Language spoken in the home: _____
If child is in DCBS custody, name and phone of DCBS case worker: _____

Reason for Referral:

Concerns about (circle all that apply):

- Motor Social-emotional Adaptive Cognitive
Hearing Vision
Communication

Audiological exam completed? Yes _____ No _____ Audiologist Name: _____

Diagnosed Condition expected to lead to developmental delay: _____

IDC-9 Code(s): _____

Helpful Notes:

