Demographic Screen

*Intake Coordinator:		
Primary/Ongoing Coordinator:		
*Child's Name:		
Social Security #:		
*Date of Birth:		
*Gender:		
Ethnicity / Race:	◯ Hispanic/Latino ◯ Asian ◯ Black/African American ◯ American Indian/Alaska ◯ Native ◯ Native Hawaiian/Other ◯ Pacific Islander ◯ White ◯ Two or more races **(Warning: You could save page without Race, but will need it before you can develop an IFSP)** (Instruction: Ask, Do you identify your child as Hispanic/Latino? If parent says yes, this is the only response needed. Mark it and skip to #6. If parent says no, ask them to choose from among the remaining choices.)	
*Child's Residence (address):		
2nd Residence (address):		
Language Used at Home:	◯ Interpreter Needed	◯ Interpreter Waived
Preferred Language/Instruction:		
Current LEA:		
Parent Restriction of Rights?	◯ Mother ◯ Father Reason?	
Does this child have an open case with DSS/CPS?	◯ Yes	◯ No
Is child currently in home or out of home?	◯ In home	◯ Out of home?
Child requires educational surrogate parent?	◯ Yes	◯ No
Household member names and relationships:		
Comments:		
*Emergency Contacts (other than parents/guardians)	***Contact 1:** Name- Home Phone- 2nd phone- Email- Note-	***Contact 1:** Name- Home Phone- 2nd phone- Email- Note-

Referral Screen

*Referral Date:	
Referral Acknowledgement Date:	
Reason for Referral:	
Is there a developmental Concern?	
*Referral Source:	Agency/Relationship to Child: Name/Agency: Phone: Address: Email: How did the referral source hear about BabyNet?
*Previous Screenings	◯ Communication ◯ Hearing ◯ Motor ◯ Overall Development ◯ Social/Emotional ◯ Vision ◯ Autism ◯ N/A
Previous Services and Providers:	
Previous Screening/Service Comments:	
Parents have consented for the following agencies to receive child specific data:	◯ DHEC/Children with Special Healthcare Needs ◯ Early Head Start ◯ EDHI/First Sound ◯ Local School/Lead Education Agency ◯ Primary Care Physician as recorded on Health Screen ◯ SSI/Disability ◯ State Longitudinal Data System
Comments on Release of Information:	
*Referral Initial Contact Attempt Date: (mm/dd/yyyy)	
*Referral Actual Contact Date: (mm/dd/yyyy)	
*Intake Visit Date: (mm/dd/yyyy)	
Comments:	

Health Screen

Health Information

*Primary Physician/Healthcare Provider (name, address, phone):	
Other Physician/Healthcare Providers (name, specialty, phone):	
Medication/Equipment:	
Emergency Factors:	
Bacterial Meningitis?	◯ Yes ◯ No If yes, flag for audiological screen.
Family History of Early Onset Hearing Loss?	◯ Yes ◯ No If yes, flag for audiological screen.
Severe Head Trauma?	◯ Yes ◯ No If yes, flag for audiological screen.
Prolonged Otitis Media and/or Middle Ear Fluid Greater than 2 Months?	◯ Yes ◯ No If yes, flag for audiological screen.
Gender:	◯ Male ◯ Female
Syndromes Associated with Hearing Loss (Flag for Audiological Screen):	◯ Agenesis of the Corpus Callosum ◯ Brachmann-De-Lange Syndrome ◯ Crouzon Syndrome ◯ Hearing Loss > 20 dB ◯ Kneist Dysplasia ◯ Neurofibromatosis 2 ◯ Stickler Syndrome ◯ Auditory Atresia ◯ Branchiootorenal (BOR)/Meinick-Fraser ◯ Goldenhar Syndrome ◯ Jackson Weiss Syndrome ◯ LADD Syndrome ◯ Norrie Disease ◯ Waardenburg Syndrome ◯ Auditory Neuropathy ◯ Cleidocranial Dysplasia ◯ Hajdu Cheyney Syndrome ◯ Kearnes-Sayne Syndrome ◯ Microtia ◯ Perrault Syndrome
Syndromes Associated with Vision Loss (Flag for Vision Screen):	◯ Albanism ◯ Bilateral retinal detachment w/ Blindness ◯ Cortical Blindness ◯ Mobius Syndrome ◯ Retinoblastoma ◯ Stickler Syndrome ◯ Anophthalmia ◯ Optic Nerve Atrophy ◯ ROP stages 4 and 5 ◯ Bilateral Optic Nerve Coloboma ◯ Cataracts w/ visual impairment ◯ Lebers amaurosis ◯ Retinitis pigmentosa ◯ Septo-optic dysplasia ◯ Bilateral Visual Acuity <20/70 corrected vision best eye ◯ Glaucoma with visual impairment

Health Comments:	
Birth Information	
Birth Weight:	_____lbs _____oz (_____ grams) (if less than 3 lbs 4.8 oz, flag for audio screen)
Birth Length:	_____ inches
Gestational Age	_____ weeks gestation (if less than 34 weeks, flag for audio screen)
Multiple Birth	◯ Yes ◯ No
Special Considerations	◯ Bilirubin = 20 mg per dl ◯ Birth defects involving craniofacial structure (i.e. ear anomaly ◯ Brain Bleeds ◯ Breathing Difficulties ◯ Breech Birth ◯ Congenital Infection (i.e. cytomegalovirus, herpes, toxoplasmosis) ◯ Cord around neck ◯ C-Section Birth ◯ Delayed Crying ◯ Feeding Difficulties ◯ Forceps/Vacuum Extraction ◯ Jaundice ◯ Low Birth Weight (<1200 gram) ◯ Meconium Staining ◯ Other ◯ Prematurity (< or = 28 weeks gestational age) ◯ Seizures ◯ Surgeries
Birth Comments:	
Pregnancy Information	
Which pregnancy is this?	(1, 2, 3, 4, 5, 6, other)
Month of Pregnancy in which routine prenatal care began?	1, 2, 3, 4, 5, 6, 7, 8, 9
Pregnancy Complications/Illnesses:	◯ Alcohol Use ◯ Anemia ◯ Bleeding ◯ Chronic Disease ◯ Elevated Blood Pressure ◯ Gestational Diabetes ◯ Illegal Drug Use ◯ Infections ◯ Over the Counter Drug Use ◯ Physician Ordered Bed rest ◯ Prescription Drug Use ◯ Pre-term Labor ◯ RH Incompatibility ◯ Tobacco Use ◯ Toxemia/Preeclampsia ◯ Trauma ◯ Vomiting
Medication Taken During Pregnancy:	
Pregnancy Comments:	

Parent Screen

Parent/Guardian One Information:

*Name:	◯ Same address as Child
Relationship to Child:	
Mailing Address:	
Phone: Home: Work: Cell:	
Email:	
Occupation:	
Employer:	
Highest Level of Education:	
Date of Birth:	
Parent One Comments:	

Parent/Guardian Two Information:

Name:	◯ Same address as Parent One
Relationship to child:	
Mailing Address:	
Phone: Home: Work: Cell:	
Email:	
Occupation:	
Employer:	
Highest Education Level:	
Date of Birth:	
Parent Two Comments:	

Financial Support Screen

*Current Family Financial Support/Services:	◯ CCSHCN/Title V ◯ Early Childhood Mental Health ◯ Early Head Start ◯ Home Health ◯ Hospice Services ◯ Medicaid Managed Care ◯ Medicaid Waiver ◯ Medicaid/EPSDT ◯ Medicare ◯ Neonatal Follow-up Clinic ◯ None Besides Early Intervention ◯ Private Insurance ◯ SSI ◯ Traumatic Brain Injury Trust Fund ◯ TRICARE ◯ WIC

Primary Insurance:			
*Insurance Company:		*Policyholder's Name:	
*Policy #:		*Policyholder's Relationship to Insured:	
*Insurance Effective Date: (MM/DD/YYYY):		*End Date:	
*Group #:		*Policyholder's Employer:	
*Phone # for Claims:		*Policyholder's DOB:	
*Latest Insurance Verification:			
*Address:			
Secondary Insurance:			
Insurance Company:		Policyholder's Name:	
Policy #:		Policyholder's Relationship to Insured:	
Insurance Effective Date: (MM/DD/YYYY):		End Date:	
Group #:		Policyholder's Employer:	
Phone # for Claims:		Policyholder's DOB:	
Latest Insurance Verification:			
Address:			
Medicaid			
Medicaid #:			
Medicaid Choice:		Medicaid Organization:	
Medicaid Ineligible Period:	_____to_____	_____ to _____	_____ to _____
Comments:			

Annual Household Income:	◯ Family Refuses Income Verification
Proof of Income:	
Household Size:	
Siblings in EI System:	
Family Share:	
Not Billable Due to:	◯ Sibling in EI ◯ Bankruptcy ◯ Low Income ◯ Temporary Suspension ◯ N/A
NOTE:	

Screening Screen

*Date Screening Received/Conducted:		
Child's Chronological Age:		Child's Adjusted Age:
*Informant Name:		Relationship to Child:
Screening Procedures:	◯ Parent/Guardian Interview w/ Staff Assistance ◯ Screening Received from other source ◯ Parent/Guardian completed w/o staff assistance ◯ Other (explain in note)	
Previous Screening History-Completed as needed	Screening Agency 1:	Date of Screening by this agency:
	Screening Agency 2:	Date of Screening by this agency:
Name of Professional if not First Steps:		
Screening Tool 1:		Screening Tool 2:

ASQ-III: Questionnaire Used (12m, 14m, 24m, etc.): _____ months

AREA	Total Score	Scores in Black Area	Scores in Gray Area	Scores in White Area
Communication		◯	◯	◯
Gross Motor		◯	◯	◯
Fine Motor		◯	◯	◯
Problem Solving		◯	◯	◯
Personal-Social		◯	◯	◯

Summary of Questions 1-9 from score sheet:

ASQ-SE: Questionnaire Used (12m, 14m, 24m, etc.) _____ months

AREA	Total Score	At Risk	No Concern
Social-Emotional		◯	◯

Autism Screening: M-CHAT: ◯ Passed ◯ Indicates Risk- 3 non-critical items
◯ Indicates Risk- 2 critical items ◯ F/U Interview Indicates Risk ◯ Stat Passed ◯ Stat Indicates Risk

Scores/Results of other screeners(If applicable):

Actions:	◯ Screening shows potential concern(s), referred for Eligibility Evaluation ◯ Screening shows potential concerns, family chooses not to proceed (This would bring you to the transition page, please choose 'Parent Withdraw' as the exit reason) ◯ Screening passed but referred for Eligibility Evaluation due to parent request ◯ Screening passed but referred for Eligibility Evaluation due to professional judgment/ICO. ◯ Screening Passed, Discharge (This would bring you to the transition page, please choose 'Screening Passed' as the exit reason) ◯ Screening shows potential concerns, referred for further Autism Screening and Assessment Date Letter Sent: (mm/dd/yyyy)

Note:

Evaluation/Assessment Information

Health:

Established Risk Condition and/or Other Health Concerns:
◯ Initial ◯ Ongoing Assessment ◯ Re-Evaluation

E/R Diagnosis Code:

Other Diagnosis Codes:

*Date of Verification of medical report (including E/R diagnosis if any):

Child Health Status: ◯ No Concern ◯ Minor Concern ◯ Major Concern

Clinical Observations:

Verified By:

Recommendations:

Notes:

Hearing:

◯ Initial ◯ Ongoing Assessment ◯ Re-Evaluation

Verification Date: ◯ Is there a Hearing Concern?

Screening Method:

*Clinical Observations:

Screened By:

Recommendations:

Notes:

Vision:

◯ Initial ◯ Ongoing Assessment ◯ Re-Evaluation

Verification Date: ◯ Is there a Vision Concern?

Screening Method:

*Clinical Observations:

Screened By:

Recommendations:

Notes:

5 Area Evaluation/Assessment:	
◯ Initial ◯ Ongoing Assessment ◯ Re-Evaluation	
*Evaluation/Assessment Completed Date:	
Evaluation Instrument:	
Assessment Method:	
Evaluator:	
Environment, Health, and Behavioral Observations:	
Domain Specific Information:	
Self Help (Adaptive)	
Developmental Age: _____to_____	% of Delay Range: _____to_____
Standard Deviation:	Developmental Quotient/Standard Score:
Clinical Observations:	
Notes:	
Social Emotional	
Developmental Age: _____to_____	% of Delay Range: _____to_____
Standard Deviation:	Developmental Quotient/Standard Score:
Clinical Observations:	
Notes:	
Communication	
Developmental Age: _____to_____	% of Delay Range: _____to_____
Standard Deviation:	Developmental Quotient/Standard Score:
Clinical Observations:	
Notes:	
Motor	
Developmental Age: _____to_____	% of Delay Range: _____to_____
Standard Deviation:	Developmental Quotient/Standard Score:
Clinical Observations:	
Notes:	
Cognitive	
Developmental Age: _____to_____	% of Delay Range: _____to_____
Standard Deviation:	Developmental Quotient/Standard Score:
Clinical Observations:	
Notes:	
Summary Information:	

Specialty Assessment:	
◯ Initial ◯ Ongoing Assessment ◯ Re-Evaluation	
*Evaluation/Assessment Completed Date:	
Evaluation Instrument:	
Assessment Method:	
Evaluator:	
Clinical Observations:	
Environment, Health, and Behavioral Observations:	
Developmental Age: _____to_____	% of Delay Range: _____to_____
Standard Deviation:	Developmental Quotient/Standard Score:
Recommendations:	
Notes:	

Eligibility Screen

◯ Established Risk (Must enter diagnosis in Evaluation/Assessment Screen->Health)

◯ Developmental Evaluation

*Part C Eligible Decision: ◯ Eligible ◯ Ineligible	*Determination Date:

Ineligible Reason:

Comments:

IFSP Outcome Screen

◯ Child ◯ Family ◯ Transition *Target Date_____(Never longer than 6 months)

*Outcome	*Procedure	Note	Date Reviewed	Outcome Status	Outcome Review
				◯ Achieved ◯ Continued ◯ Continued with Changes ◯ Discontinued	

◯ Child ◯ Family ◯ Transition *Target Date_____

*Outcome	*Procedure	Note	Date Reviewed	Outcome Status	Outcome Review
				◯ Achieved ◯ Continued ◯ Continued with Changes ◯ Discontinued	

◯ Child ◯ Family ◯ Transition Target Date_____

Outcome	Procedure	Note	Date Reviewed	Outcome Status	Outcome Review
				◯ Achieved ◯ Continued ◯ Continued with Changes ◯ Discontinued	

Planned Services

Outcome # (s)_____ *Start Date_____ *End Date _____

◯ Accept Service
◯ Permit Insurance
◯ Permit Medicaid

*Service Name	*Provider	*Method of Delivery	*Intensity	*Setting
			◯ Consultation ◯ Individual	

*Frequency	*Length	*Payor	Justification for non-nat. environment	Note
#_____ ◯ Weekly ◯ Monthly ◯ Semiannually	_____ Hour (s) _____ Minute (s)	_____ _____ _____		

Planned Services

Outcome # (s)_____ Start Date_____ End Date _____

◯ Accept Service
◯ Permit Insurance
◯ Permit Medicaid

Service Name	Provider	Method of Delivery	Intensity	Setting
			◯ Consultation ◯ Individual	

Frequency	Length	Payor	Justification for non-nat. environment	Note
#_____ ◯ Weekly ◯ Monthly ◯ Semiannually	_____ Hour (s) _____ Minute (s)	_____ _____ _____		

Planned Services

Outcome # (s)_____ Start Date_____ End Date _____

◯ Accept Service
◯ Permit Insurance
◯ Permit Medicaid

Service Name	Provider	Method of Delivery	Intensity	Setting
			◯ Consultation ◯ Individual	

Frequency	Length	Payor	Justification for non-nat. environment	Note
#_____ ◯ Weekly ◯ Monthly ◯ Semiannually	_____ Hour (s) _____ Minute (s)	_____ _____ _____		

IFSP Screen

*IFSP Meeting Date:	IFSP Delay Reason:
*IFSP Type:	
Informed Parental Consent:	
Parent/Guardian(s) is Legal Guardian?	◯ Yes ◯ No
Parent/Guardian(s) has parental rights as defined under Part C Regulations?	◯ Yes ◯ No
Parent/Guardian(s) participated in development of the IFSP?	◯ Yes ◯ No
Parent/Guardian(s) agreed to IFSP implementation?	◯ Yes ◯ No

Family Assessment Parent Interview Date: _____

Family Concerns:

Family Resources and Supports:

Family Priority:

Identification of Natural Environments:

*Other Services:

*IFSP Participants:

◯ Assessor(s) ◯ Child Care Provider ◯ CPS Worker ◯ First Steps County Partnership
◯ 5 Area Evaluator/Assessor ◯ Physician ◯ Potential Direct Service Provider ◯ Service Coordinator

IFSP Participants Detail:

IFSP Meeting Note:

Service Log

*Service:

*Actual or Missed Service Date	*Service Delivery Status	*Start Time	*End Time	CPT/HCPCS Code
***ICD Code**	**TCM Category**	***Service Note/Description of Intervention**		**Correction/ Addendum**

Service Log

Service:

Actual or Missed Service Date	Service Delivery Status	Start Time	End Time	CPT/HCPCS Code
ICD Code	**TCM Category**	**Service Note/Description of Intervention**		**Correction/ Addendum**

Service Log

Service:

Actual or Missed Service Date	Service Delivery Status	Start Time	End Time	CPT/HCPCS Code
ICD Code	**TCM Category**	**Service Note/Description of Intervention**		**Correction/ Addendum**