



**Referral to
TENNESSEE INFANT PARENT SERVICES**

4097 South MSU B Street, Memphis, TN. 38152 FAX: (901) 323-9478 Phone: (901) 678-3501

Referral Date: _____
Referring Agency: **UTMG Pediatrics – Primary Care Clinic** Referring Person: **Dr.** _____
Position: **Primary Care Provider** Phone: **901-448-2000**

Child's Name: _____ DOB: _____
Child's Social Security Number: _____

Parent(s) Names: _____ Home Phone: _____

Alternate Phone Numbers if available: _____

Address: _____

Street Address/Apt. No. City Zip Code County

Reason(s) for referral – check all that apply:

- Vision loss**, diagnosed. **Vision loss**, suspected.
- Hearing loss**, diagnosed. **Hearing loss**, suspected.
- Neurological impairment.** Name of condition: _____.
- Muscular impairment.** Name of condition: _____.
- Orthopedic impairment.** Name of the condition: _____.
- Organic condition or syndrome.** Name of condition: _____.
- Chromosomal, metabolic, or endocrine abnormalities.** Name of condition: _____.

Prematurity according to Tennessee's Definition of Developmental Delay

1. He or she is born at a gestational age of less than 30 weeks

OR

2. He or she is born at a gestational age of 30-36 weeks and meets at least one of the following: IUGR<10th percentile, hypoxic ischemic encephalopathy, seizure activity in the neonatal period, meningitis in the neonatal period, IVH Grade III or IV, abnormal CT/US findings, microcephaly<10th percentile for GA, or metabolic derangement. Applicable condition: _____.

OR

3. He or she is born at a gestational age of 30-36 weeks and meets at least two or more of the following criteria: APGAR score of less than three at five minutes, prolonged ventilation for apnea or hypoventilation for more than 48 hours, prolonged hypoxemia for greater than 24 hours, hypotonia for more than 48 hours, or prolonged hypotension for more than eight hours. Applicable conditions: _____

Other reasons for referral to TIPS: _____

Additional pertinent information: _____

