SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections BABYNET

PRIMARY HEALTHCARE PROVIDER SUMMARY

☐ **Initial** ☐ **Annual**

Your assistance is requested to obtain health information for the child listed below to assist in eligibility determination and service planning. **A signed consent for release of information is attached.**

SECTION 1: CHILD INFORMATION

Child's Name:	
Date of Birth:	BRIDGES ID #:
Address:	
Parent Name:	
Phone:	

SECTION 2: PRIMARY HEALTHCARE PROVIDER INFORMATION

Name:		
Address:		
E-Mail:	Phone:	Fax:

SECTION 3: CURRENT HEALTH STATUS (to be completed by primary healthcare provider)

Is this child at substantial risk for developmental delay based upon medical history or current status? ☐ No ☐ Yes
If **yes**, please describe:

Please list other or new significant medical conditions that may impact development:

Are the child's immunizations up to date? ☐ No ☐ Yes If **no**, please describe:

Are other health care providers serving this child? ☐ No ☐ Yes If **yes**, please list:

Have you/your office made referrals to other agencies to meet this child's health-related needs? ☐ No ☐ Yes If **yes**, please list:

Signature of primary healthcare provider or designated representative	*Date*

SECTION 4: INTAKE COORDINATOR OR SERVICE COORDINATOR'S CONTACT INFORMATION

Thank you for your assistance. Please return this form to the Coordinator listed below or call if you have questions about this request.

Name: ☐Intake Coordinator ☐Service Coordinator

Date Sent:

Agency:

Address:

E-mail:	Phone:	Fax: