Referral for Services

Fax: (509) 574 – 3210

Date of Referral _____ **Status: Routine ☐ Urgent ☐**

Clinic/Specialty or Service Referring To _____

CHILD INFORMATION

Last Name _____ **First** _____ **Middle** _____

DOB _____ **Gender: M ☐ F ☐ Other ☐ Previous Name** _____

Physical Address _____ **City**_____ **State** ___**Zip** _____

Mailing Address (if different than above) _____ **City**_____ **State** ____ **Zip** _____

School Attending _____ **Current Grade Level** _____

PARENT/GUARDIAN/FOSTER PARENT INFORMATION

Name _____ **DOB:** _____ **Relationship to Child** _____

Phone/Cell # (_____)_____ E-mail _____

Name _____ **DOB:**_____ **Relationship to Child** _____

Phone/Cell # (_____)_____ E-mail _____

Preferred Language: English ☐ Spanish ☐ Other _____

Is there something unique about the way medical decisions are made for your child? Yes ☐ No ☐

FINANCIAL INFORMATION

Provider One # _____ **Healthy Options Plan** _____

Private Insurance: _____ **ID #**_____**Grp#** _____

Primary Insurance: _____

Policy #_____ **Group #** _____

Subscriber _____ **Subscriber DOB** _____ **Employer** _____

Secondary Insurance: _____

Policy #_____ **Group #** _____

Subscriber _____ **Subscriber DOB** _____ **Employer** _____

Self-Pay ☐

REFERENT INFORMATION

PCP _____ **Phone #** _____

Referent _____ **Phone #** _____

Diagnosis/Reason for Referral _____

History/Current Concerns/Recommendations _____

_____

Are there concerns for this child's safety and/or is there a history of wandering when out in the community? Yes ☐ No ☐

Please attach medical records and other significant information and return with this completed form.