



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. ☞