Children and Youth with Special Health Care Needs Referral Form

Community Health Division

Referral Date:____________________
Month/Day/Year

Client Name: ______________________________ (Last, First, MI) DOB: ______________ (Month/Day/Year) Sex: ☐M ☐F Race Ethnicity: __________

Provider One #: ______________________________

Address: ______________________________ (Number, Street, Apt #)

______________________________ (City, State, Zip Code)

Telephone Number: ( ) ______________________

Message/Work No: ( ) ______________________

Medicaid Coverage: ☐ Yes ☐ No

Primary Care Provider:______________________

Interpreter Needed: ☐ No ☐ Yes Language: ______________________ Medical Insurance: ______________

Parent/Guardian (if applicable): ______________________________ DOB: ______________

Referred By (Agency): ______________________ Contact Person: ______________________

Agency Telephone: ( ) ______________________ Referral Taken By: ______________________

Is the client aware of the referral? ☐Yes ☐No

CYSHCN REFERRAL: Weight:__________ Length:__________ OFC: __________ Date: ______________

ICD-10/Diagnosis/Risk Factors: ______________________________

Agencies involved with child (Check all that apply):

☐ Any Children's Hospital
☐ IFSP/ESIT/FRC
☐ Foster Care Home
☐ Division of Developmental Disabilities
☐ Primary Care Provider
☐ Community Resources
☐ Maxillofacial Review Board
☐ Women, Infants, and Children (WIC)
☐ Neuro-Developmental Center
☐ OSPI School District or IEP
☐ Supplemental Security Income

Complications/Concerns: ______________________________

List other family members:

Last Name	First Name	DOB	Relationship

Pend Oreille County

Mail the completed form to:

CYSHCN Coordinator
Northeast Tri County Health District
605 Hwy 20
Newport, WA 99156

Or fax to:

(509) 684-9878
Attn: CYSHCN Coordinator

Ferry and Stevens Counties

Mail the completed form to:

CYSHCN Coordinator
Northeast Tri County Health District
240 E Dominion Ave
Colville,WA 99114