

## Children with Special Health Needs Program REFERRAL FOR SERVICE

Date \_\_\_\_\_

Child's Name \_\_\_\_\_  
LAST FIRST MIDDLE

Date of Birth \_\_\_\_\_ Sex/Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Mailing Address (if different from above) \_\_\_\_\_

Mother's Name \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_  
LAST FIRST M.I.

Father's Name \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_  
LAST FIRST M.I.

Legal Guardian/Other Contact Person \_\_\_\_\_  
LAST FIRST M.I.

Relationship to Child \_\_\_\_\_ Home Phone \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_

Child's Health Insurance Plan \_\_\_\_\_ Member Number \_\_\_\_\_  
IF QUEST, SPECIFY PLAN

Physician/Primary Care Provider \_\_\_\_\_ Phone \_\_\_\_\_

Dentist/Dental Provider \_\_\_\_\_ Phone \_\_\_\_\_

Reason for Referral \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Significant Information (i.e. hospitalizations, conditions/diagnoses, discharge date, evaluations conducted)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Other Agencies Involved with Contact Numbers (if additional, please attach or use other side of referral)**

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

<b>Referred By</b> _____				
<small>NAME</small>	<small>TITLE</small>	<small>AGENCY</small>	<small>PHONE</small>	<small>FAX</small>

Children with Special Health Needs Program	Oahu 733-9053	Maui 984-2130
State of Hawaii / Department of Health	Kona 322-4882	Kauai 241-3376
741 Sunset Avenue ■ Honolulu, Hawaii 96816	Hilo 974-4288	Molokai & Lanai 733-9053 ( <i>call collect</i> )