

SPECIALTY SUPPORT PROGRAM (SSP)
HAWAII STATE DEPARTMENT OF HEALTH
CHILDREN WITH SPECIAL HEALTH NEEDS BRANCH

SSP REFERRAL FORM

ISLAND (child/youth resides):	DATE SUBMITTED:
--------------------------------------	------------------------

CHILD/YOUTH INFORMATION

LAST NAME:	FIRST NAME:	BIRTHDATE:
-------------------	--------------------	-------------------

GENDER	LANGUAGE PREFERENCES	ETHNICITY(IES) OF CHILD/YOUTH (list all)
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> DECLINE <input type="checkbox"/> OTHER:	INTERPRETER NEEDED: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE If YES, please specify preferred language:	

PARENT/GUARDIAN NAME	RELATIONSHIP (to child/youth)	PHONE	EMAIL
PRIMARY CONTACT (list first)			

RESIDENTIAL ADDRESS (Street, City, State, Zip Code):	HOUSELESS: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT KNOWN
-------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------

MAILING ADDRESS if different from RESIDENTIAL (Street, City, State, Zip Code):

PRIMARY CARE PROVIDER NAME	PHONE	FAX

HEALTH INSURANCE INFORMATION – If QUEST, specify (e.g., QUEST-HMSA)		
PRIMARY INSURANCE PLAN:	SECONDARY INSURANCE PLAN (if applicable):	<input type="checkbox"/> NO INSURANCE

INFORMATION OF PERSON COMPLETING FORM			
----------------------------------------------	--	--	--

NAME	RELATIONSHIP (to child/youth) or NAME OF PROGRAM	PHONE	EMAIL

MEDICAL DOCUMENTATION SENT IN, IF AVAILABLE (Fax numbers listed below): <input type="checkbox"/> YES <input type="checkbox"/> NO

REASON FOR REFERRAL:

SUSPECTED CONDITIONS/DIAGNOSIS(ES):	OTHER AGENCIES INVOLVED OR REFERRED TO (if applicable):

PARENT/GUARDIAN CONSENT IS REQUIRED PRIOR TO MAKING A REFERRAL. Parent/Guardian has given consent for this referral: <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW DID YOU HEAR ABOUT US (check one): <input type="checkbox"/> EARLY INTERVENTION PROGRAM <input type="checkbox"/> PUBLIC HEALTH NURSE <input type="checkbox"/> FAMILY/FRIEND <input type="checkbox"/> ONLINE SEARCH/WEBSITE <input type="checkbox"/> DOCTOR <input type="checkbox"/> SCHOOL <input type="checkbox"/> COMMUNITY FAIR <input type="checkbox"/> OTHER (specify):
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

MAIN OFFICE: 741 SUNSET AVENUE, HONOLULU, HI 96816

O'ahu: Phone: 808-733-9055 Fax: 808-733-9068

Kaua'i: Phone: 808-241-3376 Fax: 808-241-3480

Maui County: Phone: 808-984-2130 Fax: 808-243-5202

East Hawai'i: Phone: 808-974-4288 Fax: 808-974-4285

West Hawai'i: Phone: 808-322-4882 Fax: 808-322-1504