



**STARTS Physician Referral Form**

**Phone (800) 704-0900**

**Fax to (408) 938-4536**

AGE 0-5 MENTAL HEALTH     AGE 0-5 KIDSCOPE     AGE 6-18 MENTAL HEALTH     AGE 6-18 KIDSCOPE     INN-01 PROJECT

<p><b>PRIMARY CAREGIVER NAME:</b>  <input type="checkbox"/> Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other:</p> <p><b>Address</b>  City _____ Zip _____  Home Phone # _____  Work # _____ Cell # _____</p> <p><b>LEGAL GUARDIAN?</b> <input type="checkbox"/> Same <input type="checkbox"/> NAME IF NOT:  Phone # _____ Fax # _____</p> <p><b>PRIMARY LANGUAGE:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other:  <b>TRANSLATOR NEEDED?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>ETHNICITY:</b> <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Alaska Native or American Indian  <input type="checkbox"/> Multiracial <input type="checkbox"/> Black/African American <input type="checkbox"/> Other:</p>	<p style="text-align: center;">Apply VMC I.D. sticker if available</p> <p><b>DATE:</b> (MM/DD/YY)</p> <p><b>CHILD NAME:</b></p> <p><b>DOB:</b> (MM/DD/YY)</p> <p><b>Gender:</b> <input type="checkbox"/> M <input type="checkbox"/> F</p> <p><b>Health Insurance</b> <input type="checkbox"/> MediCal <input type="checkbox"/> Healthy Families <input type="checkbox"/> Healthy Kids  <input type="checkbox"/> Valley Health Plan <input type="checkbox"/> Other:</p> <p><b>Subscriber ID#</b></p> <p><b>Primary Care Physician:</b></p>
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**REASON FOR REFERRAL (describe BEHAVIORAL OR EMOTIONAL difficulties and attach clinic notes)**  
*Has the child been previously screened?* Yes  No  ( identify screening tool and attach results)

Who has concerns?  Parent  Caregiver  Teacher  MD  Other:

**PREVIOUS OR SUSPECTED DIAGNOSES**

**ADDITIONAL CHILD CONCERNS, RISK FACTORS AND BIOMEDICAL ISSUES (mark all that apply and attach any School or Medical Subspecialty/Discharge records)**

Fine Motor  Gross Motor  Speech/Language  
 Social  Severe Aggression  Problem Solving/Cognitive  Self help/Adaptive  Academics  
 Prenatal Alcohol  Prenatal Drugs  NICU Grad.  Chronic Disease  Audiology  Ophthalmology  Genetics  
 Other:

**PREVIOUS & CURRENT SERVICES:**

No Services  Head Start/Preschool  Early Start Program/IFSP  Speech Therapy  Physical Therapy  Occupational Therapy  SSI  
 Special Ed/IEP  504 Plan  SARC/IPP  Mental Health  Home Visitation  Parenting Classes  FIRST 5 Services  
 Other:

**ENVIRONMENTAL EXPOSURE TO:**

Alcohol  Drugs  Low Parental Education  Teen Parent  Single Parent  Caregiver Mental Health  Gang Involvement  
 Domestic Violence  Abuse  Neglect  Molestation  CPS history  Divorce  Incarceration  Other Court History:  
 Other:

**PSYCHOTROPIC MEDS TRIED AND RESPONSE (describe or attach clinic notes)**  none

**REFERRING PHYSICIAN:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_ **FAX#:** \_\_\_\_\_