COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Kid Connections
Consultation & Assessment Collaborative for Children & Families

FIRST 5 SANTA CLARA COUNTY

STARTS Referral Form

Behavioral Health Call Center: **Phone:** (800) 704-0900**, Fax:** (408) 947-5848 **Email:** KCN.Referral@hhs.sccgov.org

1. REFERRAL SOURCE

Referring Agency / School:	Program Name / District:	Referring Person:
Referring Person's Phone:		Referring Person's Email:
Reason for Referral *(please explain on additional paper if more room is needed):*		

2. PRIMARY CAREGIVER INFORMATION

Full Name:	Relationship: ☐ Parent ☐ Grandparent ☐ Foster Parent ☐ Other: _____ Legal guardian? ☐ Same ☐ Name, if not: _____	Gender F ☐ M ☐
Ethnicity: *(mark one)* ☐ Asian ☐ Hispanic ☐ Alaska Native or American Indian ☐ Multiracial ☐ White ☐ Black/African American ☐ Other:	Primary Language: *(mark one)* ☐ English ☐ Spanish ☐ Vietnamese ☐ Other:	
Address: City: Zip:	Home Phone: Work Phone: Cell Phone:	Best time to call:

3. REFERRED CHILD INFORMATION *(age 0-5 years only)*

Full Name: Sibling/Siblings referred: ☐ Yes ☐ No	DOB: (MM/DD/YY)	Gender: F ☐ M ☐	Check if child has: ☐ FSP ☐ IEP ☐ N/A or UK
Ethnicity: *(mark one)* ☐ Asian ☐ Hispanic ☐ Alaska Native or American Indian ☐ Multiracial ☐ White ☐ Black/African American ☐ Other:		Primary Language: *(mark one)* ☐ English ☐ Spanish ☐ Vietnamese ☐ Other:	

3A. CHILD'S HEALTH INSURANCE: ☐ No Insurance ☐ Medi-Cal ☐ Valley Health Plan ☐ Other:
Health Insurance ID #: **Primary Care Physician Name***:*

Referring for Triple P? ☐ Y ☐ N **If YES, what level?** ☐ L2 ☐ L3 ☐ L4 ☐ L5 ☐ Unknown or Not Sure

3B. CHILD CONCERNS AND RISK FACTORS: ***(including concerns of caregivers and/or teachers)*** *(mark all that apply)*

☐ None/Unknown ☐ Fine Motor ☐ Gross Motor ☐ Speech/Language ☐ Problem Solving/Cognitive ☐ Severe Aggression ☐ Social
☐ Self-help/Adaptive ☐ Academics ☐ Prenatal Alcohol ☐ Prenatal Drugs ☐ Grad ☐ Feeding Issues ☐ Sleep Issues ☐ Other:

Problem Solving/Cognitive Severe Aggression NICU
Grad Feeding Issues Sleep Issues

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3C. FAMILY CONCERNS AND RISK FACTORS:

☐ None/Unknown ☐ Alcohol ☐ Drugs ☐ Low Parental Education ☐ Teen Parent ☐ Single Parent
☐ Neglect ☐ Abuse ☐ Domestic Violence ☐ Gang Involvement ☐ Caregiver Mental Health ☐ Molestation
☐ CPS history ☐ Divorce ☐ Incarceration ☐ Other Court History: ☐ Other:

3D. PREVIOUS & CURRENT SERVICES:

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

3E. Referral Comments and Specific Concerns: *(please provide additional information on behavioral concerns, or additional information as needed)*

4. Additional Comments, Notes, Information: *(preferred agency)*

Please include the following with referral: 1) KidConnections Referral Cover Sheet, 2) KidConnections STARTS Referral Form, 3) ASQ-3 and ASQ:SE 2 Summary Sheet, and 4) other information that would be relevant to referral.

Referrals cannot not be processed when referral is incomplete or missing information. Please ensure STARTS form and attachments are included to support timely referral processing.