CONFIDENTIAL

STARTS Physician Referral Form

FIRST 5 SANTA CLARA COUNTY

COUNTY OF SANTA CLARA
Behavioral Health Services

KidConnections Telephone: (800) 704-0900 **Fax:** (408) 947-5848 **Email**: KCN.Referral@hhs.sccgov.org

☐ Behavioral and Developmental Health ☐ Behavioral Health

**REFERRALS WITHOUT CLINIC NOTES AND EMAIL ADDRESSES WILL NOT BE PROCESSED.*

Referring Party Information: Name:_____ Telephone: _____ Fax: _____

Email Required (print legibly): _____

PRIMARY CAREGIVER NAME: _____

☐ Parent ☐ Grandparent ☐ Other Relative_____

☐ Foster Parent (Please include name/phone of Social Worker)

Name_____Telephone_____

☐ Other (Please include relationship) _____

LEGAL GUARDIAN? ☐ Same as Primary Caregiver

NAME/PHONE IF NOT: Name_____

Telephone _____

Primary LANGUAGE: ☐ English ☐ Spanish ☐ Vietnamese ☐ Other:

_____ (language) INTERPRETER NEEDED? ☐Yes ☐ No

ETHNICITY: ☐ Alaska Native/American Indian ☐ Asian ☐ Hispanic

☐ Black/African American ☐ White ☐ Multiracial

☐ Other: _____

Apply VMC I.D. sticker if available

DATE: *(MM/DD/YY)*

_____

CHILD NAME:_____ DOB:_____

Gender: ☐ M ☐ F

Health Insurance: ☐ Medi-Cal ☐ Valley Health Plan ☐ Other (please list below):

☐ _____

Subscriber ID#: _____

Address_____

City _____ Zip Code _____

Home Phone_____ Work Phone _____

Cell Phone_____

PRIMARY HEALTH CARE PROVIDER:

Name: _____ Telephone: _____

Email Required (print legibly): _____

REASON FOR REFERRAL (REQUIRED - ATTACH CLINIC NOTES & SCREENING TOOLS WITH DESCRIPTION OF CONCERNS)

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:

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

ADDITIONAL CHILD CONCERNS, RISK FACTORS AND BIOMEDICAL ISSUES *(mark all that apply & 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 (include in clinic notes)

PREVIOUS & CURRENT SERVICES

☐ No Services ☐ Unknown ☐ 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 ☐ Child Welfare

☐ Other (include in clinic notes)

ENVIRONMENTAL EXPOSURE/OTHER RISK FACTORS

☐ Alcohol ☐ Drugs ☐ Low Parental Education ☐ Teen Parent ☐ Parenting w/o Support ☐ Divorce ☐ Caregiver Mental Health ☐ Gang Involvement

☐ Domestic Violence ☐ Abuse ☐ Neglect ☐ Molestation ☐ Incarceration ☐ Other Court History (include in clinic notes) ☐ Other (include in clinic notes)

ADDITIONAL INFORMATION:

☐ Early Start Program/Date referral sent_____ ☐ Discussed School District/Special Education Services