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HEALTHY DEVELOPMENT SERVICES
NORTH CENTRAL INTAKE/REFERRAL FORM

Rady Children's Hospital San Diego

Date Faxed/Encrypted Emailed:

To:	**CC To:** North Central Regional Coordination	**From:**
Agency:	**Agency:** Rady Children's Hospital-San Diego	**Agency:**
Phone:	**Phone:** 858-966-7510	**Phone:**
Fax/Email:	**Fax/Email:** 858-259-3570/ northcentralhds@rchsd.org	**Fax/Email:**

Child Name: □ Male □ Female | Child DOB: | Child Age:

Ethnicity: □ African □ African-American/Black □ American Indian/Alaskan Native □ Asian □ Hispanic/Latino □ Multiracial □ Pacific Islander □ White(non-Hispanic) □ Other □ Don't know/declined

Address (including zip code):

Primary Caregiver Telephone: | Alternate Telephone:

Caregiver(s) Name(s): | Caregiver(s) DOB:

Child/Caregiver Language: | Caregiver relationship to child:

Childcare Provider: | Child's MD:

Does the child have medical insurance? □ Yes insurance carrier: □ No; refer to F5 Healthcare Access

Is the child already receiving services? □ No □ Yes, ***within*** HDS □ Yes, ***outside*** HDS
If yes, please specify what type of service and with whom:

Child has completed/date: □ ASQ □ ASQ-SE □ Family Tool □ other tools:

What services are being referred to?

□ ***Care Coordination:*** RCHSD

□ ***Bright Futures for Kids Classes*:** SAY-HSMFRC

Developmental Services:

□ **C3:** assessment/intervention

□ ***Vision Screening*:** UCSD Shiley

□ ***Hearing Screening*:** UCSD Shiley

Behavior Services:

□ **C3:** behavior classes, parent coaching

□ **Chadwick:** on-site child/family therapy

□ **Home Start:** in-home child/family therapy

□ **YMCA CRS:** consult for childcare

Also referring to services outside of HDS:

Notes/ Presenting Issues:

Consent for Release of Information (REQUIRED)

I authorize the organizations listed above to contact me regarding the child listed above for the purpose of delivering the services requested. Authorization is hereby granted for release of any information between Rady Children's Hospital San Diego and its affiliated entities to professionals treating my child, including First 5 Commission of San Diego Healthy Development Services, physicians, public health nurses, psychologists, counselors, school district personnel, CA Early Start, San Diego Regional Center, Health and Human Services Agency, California Children Services, preschools, and child care providers.

★**Verbal Consent:** ☐

Autorización Para Dar y Recibir Información (OBLIGATORIO)

Autorizo a las organizaciones mencionadas previamente que me contacten sobre el niño(a) mencionado(a) anteriormente con el proposito de proveer servicios. Autorizo al Hospital de Niños Rady, San Diego y a sus entidades afiliadas a proporcionar cualquier información a los profesionales que deban tratar a mi niño(a), incluyendo La Commission De Primeros 5 San Diego por medio del programa de Servicios para un Desarrollo Saludable, otros médicos, enfermeras de salud pública, psicólogos, consejeros, personal del distrito escolar, CA Early Start, El Centro Regional de San Diego, Agencia de Salud y Servicios Humanos, Servicios para los Niños de California, escuelas preescolares, y proveedores del cuidado de niños.

★**Autorización Verbal:** ☐

► Parent/Caregiver Signature/Firma: _____ Date/Fecha: _____

To be completed by the fax recipient with status within 14 days and updates until a determined referral outcome is established:

Date Faxed: ***To:*** ***CC fax to Reg Coord:*** 858-259-3570 ***From:***

REFERRAL UPDATE:

□ Care Coordinator _____
□ An appointment has been scheduled on: Date _____
□ Client is on a waitlist
□ Other _____

REFERRAL OUTCOME:

□ Initiated services: Service: _____ Date _____
□ Provider refused referral
□ Family declined services
□ Unable to locate or contact family

Notes: