FUNDED BY First 5 San Diego

Healthy Development Services
Clinician Referral Form

Please fax referrals to regional lead fax numbers listed below.
See list of zip codes for regional boundaries on back.

DATE:

Central:	*East:*	*North Central:*	*North Coastal:*	*North Inland:*	*South:*
(619) 544-0308	*(619) 444-0884*	*(858) 259-3570*	*(858) 259-3570*	*(760) 739-2333*	*(619) 336-8646*

To (Agency): Contact person: Phone: Fax:

From (Agency/Referral Coordinator): Contact person: Phone: Fax:

Referring Clinician:

Child's Name: DOB: ☐ Female ☐ Male

Address: City: Zip Code:

Home Phone: Alternate Phone:

Primary Language: ☐ English ☐ Spanish ☐ Other: Does the child have medical insurance? ☐ No ☐ Yes Insurance carrier:

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

Caregiver's Name: Foster parent? ☐ Yes ☐ No

Caregiver's Primary Language: ☐ English ☐ Spanish ☐ Other:

Relationship to child:

Developmental Screening/Assessment Completed? ☐ Yes ☐ No Copy Attached? ☐ Yes ☐ No

Additional Referrals Initiated (PT, OT, speech, insurance, eval., etc.)? ☐ Yes ☐ No If Yes, please describe:

Developmental/Behavioral Concerns? ☐ Yes ☐ No If Yes, please describe:

Services Requested (optional): ☐ Developmental Services ☐ Behavioral Services ☐ Parent Education, Support, & Empowerment Classes

Consent for Release of Information:

I, _____(print name) authorize the organizations listed above to contact me regarding the child listed above for the purpose of delivering the services requested. I understand that this release includes exchanging only the information listed here as it pertains to coordinating this referral for this child.

Autorización Para Dar y Recibir Información:

Yo, _____(nombre en letra de molde) autorizo a las agencias indicadas para comunicarse conmigo sobre los servicios requeridos y relacionados a mi hijo/a. Entiendo que con este documento doy permiso para intercambiar solamente la información indicada, perteneciente a la coordinación de servicios para mi hijo/a.

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

BELOW TO BE COMPLETED BY RECIPIENT

Recipient will confirm receipt of referral within 2 business days and provide a status updated within 30days.

An appointment has been scheduled for:	No appointment scheduled because:
DATE: Comments: TIME:	☐ Parent/caregiver declined services ☐ Client is on a wait list ☐ Unable to contact parent/caregiver ☐ Other:

First 5 San Diego's Healthy Development Services

How to Refer:

1. Use this chart to identify region of residence.
2. Call the region number listed for services and questions.
3. Complete and submit the HDS referral form.

CENTRAL	EAST		NORTH CENTRAL		NORTH COASTAL		NORTH INLAND		SOUTH
Tel: 619-515-2406	Tel: 619-515-2463		Tel: 858-966-7510		Tel: 858-966-8235		Tel: 877-504-2299		Tel: 619-336-8647
92101	91901	91963	92037	92123	92007	92075	92003	92066	91902
92102	91905	91977	92093	92124	92008	92081	92004	92069	91910
92103	91906	91978	92106	92126	92009	92083	92025	92070	91911
92104	91916	91980	92107	92130	92010	92084	92026	92078	91913
92105	91917	92019	92108	92131	92011	92091	92027	92082	91914
92113	91931	92020	92109	92140	92014	92672	92028	92086	91915
92114	91934	92021	92110	92145	92024		92029	92096	91932
92115	91935	92040	92111	92161	92054		92036	92127	91950
92116	91941	92071	92117		92055		92059	92128	92118
92134	91942		92119		92056		92060	92129	92135
92136	91945		92120		92057		92061	92259	92154
92139	91948		92121		92058		92064	92536	92155
92182	91962		92122		92067		92065		92173

Source: SanGIS 09/07

Program Contact Information:

CENTRAL/EAST
Family Health Centers of San Diego
Claudia Gastelum
Phone: 619-515-2405
cgastelum@fhcsd.org

CENTRAL - Elizabeth Grenke
Phone: 619.798.3639
elizabethd@fhcsd.org

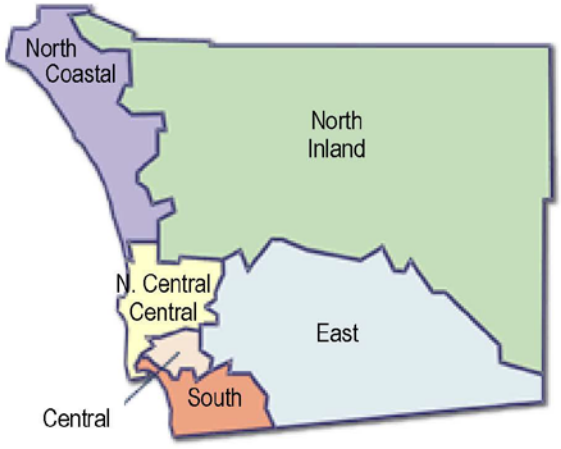
EAST - Viridiana Herrera
Phone: 619-515-2462
venriquez@fhcsd.org

NORTH INLAND
Palomar Health
Cindy Linder
Phone: 1-877-504-2299
cynthia.linder@palomarhealth.org

NORTH CENTRAL
Rady Children's Hospital-San Diego
Helen Hayden-Wade
Phone: 858-966-1700 x6902
hhaydenwade@rchsd.org

NORTH COASTAL
Rady Children's Hospital-San Diego
Robyn Igelman
Phone: 858-966-1700 x 7346
rigelman@rchsd.org

SOUTH
South Bay Community Services
Sally Fimbres-Rumpf
Phone: 619-336-8647
Mobile: 619-517-6704
sfimbres@csbcs.org



COUNTYWIDE COORDINATOR
American Academy of Pediatrics, California Chapter 3
Lily Valmidiano
Phone: 619-281-2292
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American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
California Chapter 3 - San Diego and Imperial Counties

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