**Integrated Care**



**Child & Adolescent Referral**

**Referral Type**

School-Based Clinic  FQHC Four Corners Oakhurst  Public Health Dept  Private PCP

DFCS  Other  If Other please specify :Click here to enter text.

**Referring Party**

|  |  |  |  |
| --- | --- | --- | --- |
| Name/Position: | Click here to enter text. | Agency: | Click here to enter text. |
| Email: | Click here to enter text. | Phone: | Click here to enter text. |

**Health Concern:** Briefly describe youth’s physical health concern/s for which they may need to receive ongoing care.

|  |  |
| --- | --- |
| Health Concern: | Click here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| Pediatrician Name: | Click here to enter text. | Phone Number: | Click here to enter text. |

**Youth & Family Information**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | Click here to enter text. | | | | | | | | | | | | SSN: | | | Click here to enter text. | |
| Age: | Click here to enter text. | | | | | | Date of Birth: | | Click here to enter text. | | | | Gender: | | | Choose an item. | |
| School: | | Click here to enter text. | | | | | | | | | Grade: | | | : Click here to enter text. | | | |
| Special School Services: | | | | | Click here to enter text. | | | | | | | | | | | | |
| Agencies Involved: | | | Choose an item. | | | | Please specify “Other:” | Click here to enter text. | | | | | | | | | |
| Insurance: | | | | Choose an item. | | |  |  | | | | Policy Number: | | | | | Click here to enter text. |
| Name of Parent or Guardian: | | | | | | Click here to enter text. | | | | Relationship: | | | | | Choose an item. | | |
| Relationship “Other” Please Specify: | | | | | | Click here to enter text. | | | | | | | | | | | |
| Email: | | | | | | Click here to enter text. | | | | Phone: | | | | | Click here to enter text. | | |

**Presenting Circumstances/Concerns**

Click here to enter text.

Please complete all fields and email to [youthservices@vphealth.org](mailto:youthservices@vphealth.org)

**Also, indicate in the subject line of the email: “Integrated Care Referral”**