**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

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