Children and Youth with Special Health Care Needs Referral Form

Community Health Division

Referral Date: ________________
Month/Day/Year

Client Name: ______________________ (Last / First / MI) DOB: __________ (Month/Day/Year) Sex: ☐M ☐F Ethnic Group: __________

Provider One #: ______________________

Address: ______________________ (Number / Street / Apt #)
______________________ (City / State / Zip Code)

Telephone Number: ( ) __________
Message/Work No: ( ) __________
Medicaid Status: ☐ Approved ☐ Pending ☐ Denied
Primary Care Provider: __________

Interpreter Needed: ☐ No ☐ Yes Language: __________ Medical Insurance: __________

Parent/Guardian (if applicable): ______________________ DOB: __________

Referred By (Agency): __________ Contact Person: __________

Agency Telephone: ( ) __________ Referral Taken By: __________

CYSHCN REFERRAL: Weight: ________ Length: ________ OFC: ________ Date: ________

ICD-10/Diagnosis/Risk Factors: ______________________

Agencies involved with child (Check all that apply):

- ☐ Any Children's Hospital
- ☐ IFSP/ESIT/FRC
- ☐ Foster Care Home
- ☐ Division of Developmental Disabilities
- ☐ Primary Care Provider
- ☐ Community Resources
- ☐ Maxillofacial Review Board
- ☐ Women, Infants, and Children (WIC)
- ☐ Neuro-Developmental Center
- ☐ OSPI School District or IEP
- ☐ Supplemental Security Income

Complications/Concerns: ______________________

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List other family members:

Last Name	First Name	DOB	Relationship

Please mail the completed form to:

CYSHCN Coordinator
Snohomish Health District
3020 Rucker Avenue, Suite 203
Everett, WA 98201

Or fax to:

(425) 339-5255
Attn: CYSHCN Coordinator

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