|  |  |
| --- | --- |
| Child's Name:  | DOB:  |
| Parent(s) Name(s):  |
| Address:  |
| City:  | State:  | Zip:  |
| Phone:  | Work:  | Cell:  |
| Prime #:  | SSN:  |
| Language spoken in home: | [ ]  English  | **[ ]** Other**:**  |
| Primary Physician:  | Phone:  |
| Diagnosis:  |
|  |
|  |

|  |  |
| --- | --- |
| **Referral Information:**  | Date of Referral:  |
| [x]  Medically Fragile Children’s UnitDoes the family know they are being referred to us? [ ]  Yes [ ]  No |
| Name of Referral Source:  |
| Phone number:  |

|  |  |
| --- | --- |
| **County Information:**  | County Name:  |
| Case Manager's Name:  | Phone:  |

|  |
| --- |
| **Other Known Agencies and/or Programs involved with Family/Child**:Is child receiving SSI? [ ]  Yes [ ]  No [ ] CAF [ ] SDSD [ ] CACOON [ ] EI/ECSE [ ] OAC [ ] Private Insurance [ ] Other:  |
| Please list specific information about other agencies such as name of worker, phone number, and specific services, if known:  |
|  |
|  |

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| --- |
| **Family Information:**Private Insurance:  |
| Phone Number:  |

|  |
| --- |
| **Presenting Medical Issues**: (Please check off conditions that apply.) |
| [ ]  Ventilator:  |
| [ ]  Trach:  |
| [ ]  G Tube:  |
| [ ]  Seizures:  |
| [ ]  Oxygen:  |
| [ ]  Has child had 911 code/resuscitation in last year? [ ]  Yes [ ]  No |
| Other presenting issues:  |
|  |
|  |
|  |

|  |  |
| --- | --- |
| **Hospital Referral:** [ ]  Yes [ ]  No  | Discharge Date:  |
| Nursing Agency Contacted: [ ]  Yes [ ]  NoName of Agency Contacted: |
|  |
| **Recommendations:**Recommend formal Intake: [ ]  Yes [ ]  NoIntake given to:  |
| Medically Fragile Children’s Unit Criteria Score: Date:  |
|  |
| **Follow–Up:** |  |
| [ ]  Opened for Services  | Service Coordinator:  |
| [ ]  Referred Out |
| ***Waiver filled out*** [ ]  Yes [ ]  No***Children’s Medical Project (CMP) Paper Work Completed*** [ ]  Yes [ ]  No |

**Contact:** **Please email Completed form to: CIIS.Referrals@dhsoha.state.or.us**

Phone: () -2285 (or) FAX: