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

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

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| --- |
| **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: |

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| --- |
| **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: |
|  |
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| --- | --- | --- |
| **Hospital Referral:**  Yes  No | | Discharge Date: |
| Nursing Agency Contacted:  Yes  No  Name of Agency Contacted: | | |
|  | | |
| **Recommendations:** Recommend formal Intake:  Yes  No  Intake 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: