

Referral Form

Referring Source Name _____ Referral's Number _____
Child's Name _____ D.O.B. _____
Parent/Guardian Name _____ Primary Number _____
Primary Address _____
City _____ Zip _____
Child's Health Plan _____ Child's Medicaid ID _____

For Physicians/Clinicians, Community Agencies or Schools
I have spoken to parent about KHC and they agree to allow KHC to contact them <input type="checkbox"/> Yes <input type="checkbox"/> No

I – ASTHMA – Case Management (MATCH) Education

Education/Support Interventions For:

- Newly diagnosed asthma
- Assistance implementing management plan
- Interference with activity/school/family life
- Inappropriate use of ER/urgent care/rescue medications
- Care coordination with school

II – BEHAVIORAL HEALTH – Child

Facilitate Coordination With:

- Community Resources (Select one below)
 - Clothing Housing Food Banks Utilities
- Specialty Care
 - Cognitive Impairment/Learning Disability Autism
- IEP School
- Mental Health (Select one below)
 - Anxiety Disorder Depression Eating Disorder ADD/ADHD

Comments _____

III – EMERGENCY ROOM USAGE

Education/Support Interventions For:

- Child has inappropriately used the ER two or more times within the last six months

Reason(s) _____

IV – MISSED VISITS/WELL CHILD CARE

Education/Support Interventions For:

- Child has missed two or more scheduled appointments within the last six months
- Child is behind on immunizations or well child visits
- Child needs to be seen ASAP for _____

V – WEIGHT CONCERNS

FitKids 360:

- BMI at or above the 85th percentile
- I certify this child is cleared for participation in the FitKids 360 program

PCP Name _____

Signature _____

VI – OTHER

Education/Support Interventions For:

- Meeting basic needs
- Accessing community resources

ADDITIONAL COMMENTS

