HEALTHY DEVELOPMENT SERVICES

REFERRAL FORM

Please fax referrals to regional fax numbers listed below. Refer to list of zip codes on back for regional boundaries and contact information.

Fax to HDS office in: **(please check one)**

- ☐ **Central:** (619) 544-0308
- ☐ **East:** (619) 444-0884
- ☐ **North Central:** (858) 966-7521
- ☐ **North Coastal:** (858) 259-3570
- ☐ **North Inland:** (760) 796-6855
- ☐ **South:** (619) 420-8722

From contact person: **Organization:** **Phone:** **Fax:**

Child Name: □ Male □ Female Child DOB:

Address (including zip code): Caregiver Language:

Primary Caregiver Telephone: Alternate Telephone:

Caregiver(s) Name(s): Caregiver relationship to child:

Services Requested:
Contact regions for more information on available services.

- ☐ Care Coordination
- ☐ Parent Education, Support & Empowerment
- ☐ Developmental Services
- ☐ Vision
- ☐ Hearing
- ☐ Behavioral Services
- ☐ Behavioral Consulting for Childcare

Specifically:

Developmental/ behavioral services received/receiving:

Notes/Comments:

Consent for Release of Information (required):

I, ____(print name) authorize the organizations listed above to contact me regarding the child listed above for the purpose of delivering the services requested. I understand that this release includes exchanging only the information listed here as it pertains to coordinating this referral for this child.

Verbal Consent: □

Autorización Para Dar y Recibir Información (obligatorio):

Yo, ________________________________ (nombre en letra de molde) autorizo a las agencias indicadas para comunicarse conmigo sobre los servicios requeridos y relacionados a mi hijo/a. Entiendo que con este documento doy permiso para intercambiar solamente la información indicada, perteneciente a la coordinación de servicios para mi hijo/a.

Autorización Verbal: □

► Parent/Caregiver Signature/Firma: ______________________________ Date/Fecha: __________

Recipient will confirm receipt of referral within 2 business days and will provide a referral status within 30 days ↓

Date Faxed: *To:* *From:*

REFERRAL STATUS:

- □ *Referral received/Care Coord. assigned* _________________________
- □ *No appointment/contact has been scheduled/made because (check):*
  - □ *Family declined services*
  - □ *Unable to locate or contact family*
  - □ *Provider refused referral (e.g. did not meet eligibility criteria)*
  - □ *Client is on a waitlist*
  - □ *Other* ____
- □ *An appointment has been scheduled on: Date*_______________
- □ *Initiated services: Service:* __________________ *Date*_________
  - *Service:* __________________ *Date*_________
  - *Service:* __________________ *Date*_________

NOTES:

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HEALTHY DEVELOPMENT SERVICES

Please use this chart to identify region of residence.
Please call numbers listed below to reach a Care Coordinator if you have any questions:

Rady Children's Hospital		Palomar Pomerado Health	South Bay Community Services	Family Health Centers	
858-966-1700 x 7347	858-966-8235	760-796-6879	619-420-3620	619-515-2406	619-515-2463
North Central	**North Coastal**	**North Inland**	**South**	**Central**	**East**
92037	92007	92003	91902	92101	91901
92093	92008	92004	91910	92102	91905
92106	92009	92025	91911	92103	91906
92107	92010	92026	91913	92104	91916
92108	92011	92027	91914	92105	91917
92109	92014	92028	91915	92113	91931
92110	92024	92029	91932	92114	91934
92111	92054	92036	91950	92115	91935
92117	92055	92059	92118	92116	91941
92119	92056	92060	92135	92134	91942
92120	92057	92061	92154	92136	91945
92121	92058	92064	92155	92139	91948
92122	92067	92065	92173	92182	91962
92123	92075	92066			91963
92124	92081	92069			91977
92126	92083	92070			91978
92130	92084	92078			91980
92131	92091	92082			92019
92133	92672	92086			92020
92140		92096			92021
92145		92127			92040
92161		92128			92071
		92129			
		92259			
		92536			