Health and Developmental Services Referral Form

Please fax referrals to regional lead fax numbers listed below. See list of zip codes for regional boundaries.

Referral status: ☐ Initial Referral ☐ Services Provided/Follow Up

FAX	Central (619) 544-0308 East: (619) 444-1249	North Central: (858) 966-7521 North Coastal: (858) 793-1153	North Inland: (760) 796-6855 South: (619) 420-8722

Organization Referred from:	**Contact person:**	**Phone:**	**Fax:**
Organization Referred to:	**Contact person:**	**Phone:**	**Fax:**
Date:	**Child's Name:**	**Child's Language:**	**Child's DOB:**
Name of Parent/ Primary Caregiver:		**Caregiver Phone:**	**Alternate Phone:**
Parent/Caregiver Address:			
Relationship to child:		**Foster parent?** ☐	**Primary Care/Child Care Zip Code (If applicable):**
Caregiver aware of referral? ☐ **Yes** ☐ **No**		**Meets low-income guidelines?** ☐ **Yes** ☐ **No**	

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

☐ Parent Support/Empowerment	☐ Newborn Home Visit	☐ Vision
☐ Behavioral Services	☐ At-Risk Home Visit	☐ Hearing
☐ Health/Behavioral Consulting	☐ Developmental Services	☐ Speech/Language

Specifically:

Services currently received from within HDS network:

Services currently received from other sources:

Notes/Comments:

Consent for Release of Information:

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:

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: __________

Additional conditions or considerations for release of information:

↓ TO BE COMPLETED BY RECIPIENT AND FAXED BACK WITHIN 5 BUSINESS DAYS: ↓

An appointment has been scheduled for Date: ____________________ Time: ________________________

No appointment scheduled because: ☐ Parent/caregiver refused services ☐ Unable to contact parent/caregiver ☐ Client is on a wait list ☐ Other:

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