



**Referral Form**  
**Children with Special Health Care Needs (CSHCN) Program**  
**Clark County Public Health**  
**Phone: (360) 397-8440 or FAX: (360) 397-8442**

Date of Referral: \_\_\_\_\_  
(MM/DD/YY)

Referral Source: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Name of Person/Agency making referral Referent's Phone #

Child: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M F  
Last, First M mm/dd/yy

Race/Ethnicity: \_\_\_\_\_ Medicaid: Y N Assigned Plan \_\_\_\_\_

Healthcare Provider: \_\_\_\_\_ Insurance: \_\_\_\_\_ SSI: Y N

Parent(s) Name: \_\_\_\_\_

\_\_\_\_\_ Street Address/PO Box City State Zip

\_\_\_\_\_ Phone # 1 \_\_\_\_\_ Phone # 2

Parent(s) Informed of Referral: Y N Interpreter Needed: Y N Lang. \_\_\_\_\_

All Diagnoses: \_\_\_\_\_

Concern/Needs: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Internal Use (CCPH):**

Additional Referral Info: **B C D F I M N P R S W**

Referral Received on: (date) \_\_\_\_\_ by: \_\_\_\_\_

Referral Assigned To: \_\_\_\_\_

Name: _____ <small>Last, First MI</small>
DOB: _____ Sex: F M <small>mm/dd/yy</small>
HRN: _____

File Under: HISTORY Rev. 2/2014 js  
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