The CARE Network Referral Form

This template is intended for use by county social service agency referrals of children to a CARE Network medical or behavioral health provider.

Date of Referral:	
Referring Professional:	Agency:
Email Address:	Phone:

Case Name:	Trails ID:	HH #:
Child Name (D.O.B):		
Ethnicity:	Gender:	Age:
Case Family Address:		
Case Family Phone:		

Service Requested:

☐ Medical Provider evaluation – includes full medical history, physical exam, developmental assessment and behavioral health screen with focus on trauma symptoms, depression and suicide. If appropriate, will also include needed testing/labs.

☐ Specific Medical Testing (Type: _____)

☐ Behavioral Health Provider evaluation

☐ Specific Behavioral Health Screening (Type:_____)

☐ Developmental Screening (Type:_____)

Child Insurance (Insurance will be billed for services):

☐ Self- Pay *(Private Pay Contract must be signed prior to services staring)*

☐ Medicaid (*Medicaid services are subject to approved authorization)*

Medicaid #:

☐ Private Insurance

Insurance carrier and #:

Additional Services

List additional services or additional involved that child is receiving.

Family Structure

List all other case family members including parents, siblings, and/or significant others involved:

Name	Relationship to Client	Phone Number

Presenting Problem/Case Information

Please include information on any active restraining orders or safety concerns/risks, along with any known medical, behavioral, emotional, or developmental issues. If child is in DHS custody make sure to list that and that report results should go to CM.

Foster Parent/Kin Provider/Caregiver Information

List current guardian(s) for the child(ren), contact information, and address(es), if applicable:

**** Make Sure to Attach ROI with This****