REFERRAL FORM FOR FAMILIES[1]

Referral form to be completed by partners for distribution to client families.

This tool may be adapted for use by you and your partner organization to document client referrals to programs within or outside the partnership, offering a record for both the referral source and the program. This form provides a space for the client to decide if information can be shared with referral source.

Please PRINT to complete this form for referring a child/family for early childhood services.
Also please indicate the feedback that you want to receive from the receiving program in response to your referral.

Section 1. Program Referral (☑)

REFERRAL TO: (check one)

☐ Medicaid High Risk Infant/Maternal Program	☐ CHIP	☐ Part C Early Intervention
☐ Healthy Families	☐ Resource Mothers	☐ Early Childhood SPED
☐ Loving Steps	☐ Project Link	☐ Early Head Start/Head Start
☐ Appropriate Home Visiting Program	☐ Other:	

Section 2. Who Is Making This Referral?

Person Making Referral:__________________________________ Date of Referral:_____/_____/_______

Agency/Program:____

Address:____

Office Phone:________/________-__________________________ Office Fax:________/________-______________________

Email:____

Signature:____

Section 3. Who is Being Referred? (Complete as applicable)

☐ Child ☐ Pregnant Woman/Teen ☐ Mother ☐ Father ☐ Family

[1] Adapted from: Virginia's Home Visiting Consortium Universal Referral Form

Name of Infant/Child Being Referred___________________________________		Date of Birth: _____/_____/_____	Gender: M F
Home Address: ____		City:________________________ VA Zip__________	
Primary Parent/Caregiver____		Relationship to Child: ___________________________	
Primary Language:____________________	Home Phone:_________________________	Other Phone:__________________________	
Name of Pregnant Woman/Teen Being Referred:_________________________		Date of Birth: _____/_____/_____	EDD __________
Home Address:____		City_________________________ Zip__________	
Primary Language:____________________	Home Phone:_________________________	Other Phone:__________________________	
Name of Parent/Caregiver Being Referred: __________________		Date of Birth: _____/_____/_____	Gender: M F
Home Address:____		City_______________________ Zip___________	
Primary Language:_____________________	Home Phone:________________________	Other Phone:_________________________	

Best time to call or visit: ______________________________

Section 4. Reason(s) for Referral and Referral Information (☑)

☐ Pregnant		☐ Premature Birth	☐ Diagnosed medical condition
☐ New Parent		☐ Teen Pregnancy	☐ Custodial Grandparent
☐ Child development services		☐ Parent Support	☐ Well child health
☐ Perinatal Depression/other mental health concerns		☐ Maternal alcohol/substance use	
☐ Parent Education/Support		☐ Other reason for referral or more information related to checked areas:	

____

Section 5. Status/Feedback Requested by the Referral Source (☑)

☐ Status of Initial Family Contact ☐ Services Being Provided to Child/Family ☐ Developmental Evaluation Results

☐ Child Progress Report/Summary ☐ Other:______________________________

☐ **Eligibility offered? If so, outcome:** ☐ **Enrollment Accepted** ☐ **Enrollment Declined**

Extent or nature of use/disclosure is limited to: (☑ or list all that apply)

☐ Screening	☐ Health/physical information & history	☐Finances & employment
☐ Evaluation/Assessment	☐ Infectious Diseases	☐Family & interpersonal functioning
☐ Treatment/service plan (IFSP/IEP)	☐ Prenatal care	☐ Services Received
☐ Progress Notes ☐ Participation in Treatment ☐ Psychological Evaluation	☐Substance use & treatment history ☐ Mental health information & treatment history ☐ Medications prescribed	☐ Other referrals being made ☐ Discharge Summary
☐ Other: ______________________________	☐ Other: ______________________________	

Specified purpose or need for use/disclosure is: Referral for Services and Coordination of Care

In order to make a referral and/or coordinate care for myself and/or ___________________________(Child's Name),

I give permission to: ____(Referral Source)

to disclose the protected health information noted above to:

____,
(Program Name, Street Address, City, State, Zip, Phone/Fax #)

I also authorize the recipient to use the information received pursuant to this authorization. As the person signing this authorization, I acknowledge that I am giving my permission to the above-named person/class of persons to disclose and use protected health information.

Permission is hereby given to: ____
(Program)

to disclose information to: ____,
(Referral Source Name, Title)

____
(Organization/Program Name)

____
Street Address/Mailing Address

____
(City, State, ZIP)

Telephone: (   ) ______________________ Fax: (   ) ______________________

I also authorize the recipient to use the information received pursuant to this authorization. As the person signing this authorization, I acknowledge that I am giving my permission to the above-named person/class of persons to disclose and use protected health information. I further acknowledge that:

This authorization ___does ___ does not extend to information placed in my record after the date I signed this form.

I acknowledge that I have read and understand the following.

- My treatment will not be affected by my willingness or my refusal to sign this form
- The referral source cannot condition the provision of treatment to me on my signing of this authorization.
- This authorization form or a copy of it will be included with my original records.
- I have the right to revoke this authorization at any time. I am aware that, if I do revoke my authorization, this will not affect any information which has already been released in accordance with this authorization.
- Federal Regulation (42 CFR Part 2) specifically prohibit individuals or agencies from re-disclosing any information regarding alcohol or substance abuse treatment without my specific authorization
- I am aware that any other information disclosed as a result of this authorization may be re-disclosure by the recipient and is, therefore, no longer protected by the provisions of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule or the Family Education Rights and Privacy Act (FERPA).

Signature of Individual (adult) or Legally Authorized Representative____

Relationship_________________________ Date _____________Signed____

If not previously revoked, this authorization will expire in: ___90 Days ___One Year ___On *(specify date or event)*__________________________________

The information may be disclosed effective: ____Immediately ___ On *(specify date)*_________________________