



CHILDREN and YOUTH with SPECIAL HEALTH CARE NEEDS Referral

Family has been informed of referral and given consent for contact: YES NO

ATTENTION: Janette Garza, CYSHCN Coordinator
Fax to (509) 764-2813

Childs Name _____ Sex _____ DOB _____ Wt _____

Mothers Name _____ Fathers Name _____

Address _____ Phone (home/msg) _____

Diagnosis/Date: _____

Concerns _____

Primary Physician/Clinic: _____

Specialists (MD, Therapist, etc): _____

Immediate Needs: _____

Upcoming Appointments: _____

Payment Source: Private INS _____ Provider One # _____

(HMO) _____ SSI _____ Other: _____

Comments _____

Other Agency Involvement: FRC (ESIT) _____ SSI _____ CPS _____ DDA _____ B-3 _____ P2P _____

WIC _____ Therapist _____ Other _____

Agency referring child: _____ Phone: _____

Name of Person Referring (Print): _____ Date: _____