Public Health – Seattle & King County Referral Form
Instructions

1. Pt. ID	Enter the client's Medical Record number or Signature ID on the line provided. (for internal use)
2. ***Name (Required field)***	Enter the client's Last Name, First Name, and Middle Initial on the line provided.
3. ***Address (Required field)***	Enter the street address of the client's home (or address where they are located) on the line provided.
4. ***City (Required field)***	Enter the name of the City where the client's address is located on the line provided.
5. ***Zip (Required field)***	Enter the Zip Code for the City where the client's address is located on the line provided.
6. ***DOB (Required field)***	Enter the date of birth for the client on the line provided.
7. SS#	Enter the Social Security Number for the client on the line provided. **Note**: If there any objections to providing SS#, leave it blank.
8. Marital Status	Enter the Marital Status for the client on the line provided. If unknown or unsure, mark it as "unknown."
9. ***Gender: M/F (Required field)***	Circle the appropriate gender for the client.
10. Home Phone	Write in the home telephone number for the client, including the area code, on the line provided.
11. Work Phone	Write in the work telephone number for the client, including the area code, on the line provided.

Note: Cellular phone, pager and/or email address can be documented in the "additional information" section

12. PIC #	Write in the Medicaid PIC number for the client on the line provided, if applicable
13. HO Plan	Write in the Medicaid Healthy Options Plan for the client on the line provided, if applicable.
14. Private Insurance **Y/N**	Circle the appropriate answer to this question, **Y** for Yes, **N** for No.
15. Message Phone	Write in the message phone number for the client, including the area code, on the line provided.
16. School year completed	Write in the highest-grade level completed, or degree achieved, for the client on the line provided.
17. Family Size	Write in total number of members in this family.
18. Income	Write in the income for the family (gross monthly income if possible).
19. Emergency Contact	Write in the name of a person to contact in case of an emergency for the client on the line provided.
20. Phone	Write in the telephone number of the emergency contact person for the client, including the area code, on the line provided.
21. ***Race (Required field)***	In this box, circle the race of the client **(circle all that apply)**. If unknown or unsure, mark it as "unknown."
22. ***Ethnicity (Required field)***	In this box, circle the ethnicity of the client **(circle one)**. If unknown or unsure, mark it as "unknown."
23. ***Interpreter Needed* Y/N *(Required field)***	In this box, circle the appropriate answer to the question, **Y** for Yes, **N** for No. If Yes, write in the language in the space provided. ."

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24. Referred by:

In this box, write in the **name of the person calling** or making the referral on the line provided. Write in the **Agency** name (name of the agency where the referral source works) on the line provided.

Where it says "**Date of referral**," write in the date referent called in the referral or the date the provider is filling out the referral on the line provided.

Where it says "**Phone**" and "**FAX**" write in the agencies telephone number and then the agency's FAX telephone number, including the area code, on the lines provided.

25. ***Agency Type (Required field)***

In this box, circle the appropriate word that corresponds to the **Agency Type** providing the referral.

	Some Examples
Hospital	Hospital
Social Services	DSHS(all services except CPS), Drug treatment facility, Medina Children's Services, Mental health services, Neurodevelopmental Centers
Self/Individual	Client refers self or parent refers child(ren)
School	TAPP, teen clinic located in a school, school nurse
Provider	Medical/Health care provider, non health dept. clinic
Health Dept.	Any provider at any HD site—examples teen clinic, WIC to PHN services
CPS	Child Protective Services

Where it says "**Family aware of referral: YES/NO**" circle the appropriate answer to the question.

Where it says "**Response to referral requested: YES/NO**" circle the appropriate answer to the question, which is indicating whether or not the referring provider wants the HD staff to contact them. Indicate in the note section if want contact before the client is called or after for feedback.

26. ***Referral Type (Required field)***

In this box, check the main reason for the referral. If it is an "**AP**" referral type, then fill out the "**EDD, GRAVIDA, PARA, and Living Children**" sections also, on the lines provided.

If it is a "**PP/NB**" referral type, then fill out the "**GRAVIDA, PARA, Living Children,** lines provided. Add **delivery date**, circle **gender**, record **BWT** (birth weight) in grams or pounds/ounces, and record 1 minute/5minute **APGARS** in spaces provided. In addition, fill out the **Gestational Age** on the line provided, then the **Infant Feeding** (circle one), and **Delivery type** (circle one). Also, write in **Mom's health care provider/phone**, on the line provided, and **Baby's health care provider/phone** on the line provided.

If it is a "**PEDS**" referral type mark the box

If it is a "**SIDS/Bereavement**" referral type, write in the **Date of Death** on the line provided.

If it is an **"Other"** referral type, mark the box.

Referral type examples

PP/NB	Postpartum/Newborn-mother &/or the newborn, both of which are less than or equal to 60 days after birth of the baby
PEDS	Pediatric referral-any referral of an infant/child(ren) older than 60 days post birth. This referral type also includes parenting referrals, Child with special health care need condition **CSHCN (Child with Special Health Care Needs) condition** are for infants & children under the age of 18 years who are at risk for or have health/developmental problems that require **more than the usual pediatric health or social services care. Examples:** Down syndrome, severe uncontrolled asthma, prematurity (<37wks gestation), LBW (<5#8oz), developmental delay, failure to thrive); CPS project, Other example: parenting referrals, examples under PEDS section
SIDS/Bereavement	Sudden Infant Death Syndrome or for any death of a child
Other	Any circumstance that doesn't fall under any of the above referral types. Examples: woman not pregnant/parenting needing resources for domestic violence or family planning; man with head lice; teen not

	pregnant/parenting in special project

27. Additional Information: Write in further information that you would like included on this referral (ie delivery hospital, birth complications, feeding/lactation problems, parent concerns, services requested) Do so on the lines provided.

28. Other patients on this Referral**:** Write in the **Pt. ID** (Medical Record number or Signature ID-for internal use only), the full **name**, **Birth date**, **Sex**, and **Race** for additional clients you would like added to this referral for services.
    - **(asterisk) (*)** by the name indicates those family members you want included on this referral for services.