GCHD
GRANT COUNTY HEALTH DISTRICT

Clear Form

1038 West Ivy, Suite 1
Moses Lake, WA 98837

CHILDREN and YOUTH with SPECIAL HEALTH CARE NEEDS
Referral

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

ATTENTION: Julia Austin, 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:** _____