SNOHOMISH HEALTH DISTRICT
WWW.SNOHD.ORG

Children and Youth with Special Health Care Needs Referral Form

Community Health Division

Referral Date:_____
Month/Day/Year

Client Name: _____ DOB: _____ Sex: ☐M ☐F Ethnic Group: _____
Last First MI Month/Day/Year

Provider One #: _____

Address: _____ Telephone Number: ( ) _____
Number Street Apt #

Message/Work No: ( ) _____

_____ Medicaid Status: ☐ Approved ☐ Pending ☐ Denied
City State Zip Code

Primary Care Provider: _____

Interpreter Needed: ☐ No ☐ Yes Language: _____ Medical Insurance: _____

Parent/Guardian (if applicable): _____ DOB: _____

Referred By (Agency): _____ Contact Person: _____

Agency Telephone: ( ) _____ Referral Taken By: _____

CYSHCN REFERRAL: Weight:_____ Length:_____ OFC: _____ Date: _____

ICD-10/Diagnosis/Risk Factors: _____

Agencies involved with child (Check all that apply):

☐ Any Children's Hospital
☐ IFSP/ESIT/FRC
☐ Foster Care Home
☐ Division of Developmental Disabilities
☐ Primary Care Provider
☐ Community Resources
☐ Maxillofacial Review Board
☐ Women, Infants, and Children (WIC)
☐ Neuro-Developmental Center
☐ OSPI School District or IEP
☐ Supplemental Security Income

Complications/Concerns: _____

List other family members:

Last Name	First Name	DOB	Relationship

Please mail the completed form to:

CYSHCN Coordinator
Snohomish Health District
3020 Rucker Avenue, Suite 203
Everett, WA 98201

Or fax to:

(425) 339-5255
Attn: CYSHCN Coordinator

3020 Rucker Avenue, Suite 203 | Everett, Washington 98201 | Phone: 425.339.3541 | FAX: 425.339.5255