SNOHOMISH COUNTY HEALTH DEPARTMENT

Children and Youth with Special Health Care Needs Referral Form

Prevention Services Division

Referral Date: _____
Month / Day / Year

Client Name: _____ DOB: _____ Sex: ❑ M ❑ F Ethnicity: _____
Last First MI

Address: _____ Telephone: _____
Number Street Apt #

_____ Message/Work: _____
City State Zip Code

Primary Provider: _____

Clinic Telephone: _____

Interpreter Needed: ❑ No ❑ Yes Language: _____ Provider One # _____

Parent / Guardian: _____ 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 County Health Department
3020 Rucker Avenue
Everett, WA 98201

Or fax to:
425-339-5255
Attn: CYSHCN Coordinator