Date of Referral_____

FAX TO 313-659-3298

Kids' HEALTH CONNECTIONS
A Program of SEMHA

Referral Form

Referring Source Name _____ Referral's Number _____

Child's Name _____ D.O.B. _____

Parent/Guardian Name _____ Primary Number _____

Primary Address _____

City _____ Zip _____

Child's Health Plan _____ Child's Medicaid ID _____

For Physicians/Clinicians, Community Agencies or Schools
I have spoken to parent about KHC and they agree to allow KHC to contact them ☐ Yes ☐ No

I – ASTHMA – Case Management (MATCH) Education

Education/Support Interventions For:

☐ Newly diagnosed asthma
☐ Assistance implementing management plan
☐ Interference with activity/school/family life
☐ Inappropriate use of ER/urgent care/rescue medications
☐ Care coordination with school

II – BEHAVIORAL HEALTH – Child

Facilitate Coordination With:

☐ Community Resources (Select one below)
  ☐ Clothing ☐ Housing ☐ Food Banks ☐ Utilities
☐ Specialty Care
  ☐ Cognitive Impairment/Learning Disability ☐ Autism
☐ IEP School
☐ Mental Health (Select one below)
  ☐ Anxiety Disorder ☐ Depression ☐ Eating Disorder ☐ ADD/ADHD

Comments _____

_____

III – EMERGENCY ROOM USAGE

Education/Support Interventions For:

☐ Child has inappropriately used the ER two or more times within the last six months

Reason(s) _____

_____

IV – MISSED VISITS/WELL CHILD CARE

Education/Support Interventions For:

☐ Child has missed two or more scheduled appointments within the last six months

☐ Child is behind on immunizations or well child visits

☐ Child needs to be seen ASAP for _____

V – WEIGHT CONCERNS

FitKids 360:

☐ BMI at or above the 85th percentile

☐ I certify this child is cleared for participation in the FitKids 360 program

PCP Name _____

Parent/Gaurdian Name _____ Signature _____

VI – OTHER

Education/Support Interventions For:

☐ Meeting basic needs

☐ Accessing community resources

ADDITIONAL COMMENTS

_____

_____

_____