Colorado Department of Public Health and Environment

HCP Referral Form

HCP Connecting Kids with Care for Children and Youth with Special Health Care Needs

SOURCE INFORMATION		DATE:
Individual completing form:		**Organization & Title:**
Phone:	**Fax:**	**E-Mail:**

TYPE OF REFERRAL	REASON FOR REFERRAL
☐ Community-based Information and/or Resources ☐ HCP Care Coordination ☐ HCP Specialty Clinic ☐ Neurology ☐ Orthopaedics ☐ Rehabilitation	

CLIENT INFORMATION		
Last Name:	**First:**	**Middle:**
Birth date:	**Known Medical Conditions:**	
Gender:		

CLIENT'S PHYSICIAN INFORMATION		
Primary Care Provider:	**Phone:**	**Fax:**
Referring Provider (if different from above):	**Phone:**	**Fax:**

FAMILY MEMBER/GUARDIAN/HOUSEHOLD INFORMATION		
Last Name:	**First:**	**Middle:**

Relationship to client: ☐ Mother ☐ Father ☐ Grandparent ☐ Sibling ☐ Legal Guardian ☐ Step-parent ☐ Foster-parent ☐ Friend ☐ Don't Know ☐ Refused ☐ Other

Language Spoken:

Interpreter Needed: ☐ Yes ☐ No

Mailing Address:	Street:	City:	State:	Zip:	County:

Phone Number (preferred):	Phone Number (alternate):
☐ home ☐ cell ☐ work	☐ home ☐ cell ☐ work

E-mail:

Does the family member need extra help to manage health care needs and services for the child/youth?
☐ Yes ☐ No ☐ Don't Know ☐ Refused

COMMENTS / ADDITIONAL INFORMATION

Please attach pertinent medical records to this referral, if available. Number of pages attached: ___

Referral Sent to Local Public Health Agency
For local public health agency contact information, please see www.hcpcolorado.org

Agency Name:	Date sent:
If completed by phone, report to whom at LPHA:	

Pueblo Department of Public Health & Environment
Phone (719) 583-4431
Fax (719) 583-4439