Health Partners Plans Referral for Services – *Pediatric Only*

Name *(First, MI, Last)*: ______________________ **Date of Birth:** ____________

Street Address: ______________________ **Unit Number** *(if needed)*: ________

City: ____________ **State:** ______ **Zip Code:** ______ **Phone:** ____________

Alt. Phone: ____________ **Email:** ____________

Gender: ☐ Male ☐ Female **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

Race *(please check all that apply)*: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other: ____________

Language: ☐ English ☐ Spanish ☐ Other: ____________

Parent/Caregiver Name: ____________ **Parent/Caregiver Phone:** ____________

HPP Pediatric Member ID: ____________ **See page 2 if there are additional children in household**

Primary Diagnosis: ____________ **ICD Code:** ______ **Date of Diagnosis:** ______

Secondary Diagnosis: ____________ **ICD Code:** ______ **Date of Diagnosis:** ______

Meal Plan: ☐ **Complete - 21 meals** ☐ **Supplemental - 11 meals (if receiving school lunch program)**

Food Allergies? ☐ Yes ☐ No Describe: ____________

Treatment Plan/Member Goal: ____________

*** Coexisting Conditions:** ____________

*** Recent Hospitalizations/ER Visits** *(Dates/Reasons)*: ____________

*** Current Height:** ______ *** Current Weight:** ______ *** Date Weighed:** ______

*** Weight History** *(including dates)*: ____________

*** Significant Lab Values** *(if available)*:

Test	Chol.	HbAlc	TG
Value			
Date *Month/Year*			

*** Current Medications or Supplements:** ____________

____

*** Ambulation or Living Environment Concerns:** ____________

Referring Physician Name: ____________ **Referring Physician Phone:** ____________

*optional information **Referring Physician Email:** ____________

See page 2 if there are additional children in household

Providers: Fax completed form to HPP Healthy Kids at (215) 967-9242.

For HPP personnel use only:

Care Coordinator Name: ____________ **Phone:** ____________

Email: ____________ **Fax:** ____________

HPP personnel: Email form to nutrition@mannapa.org or fax to (215) 496-9102.

Please call MANNA's Client Services Dept. at (215) 496-2662, option 5, with any questions or concerns.

Please list any additional children in the household who would like to receive meals. All fields must be completed in order to process the additional household members.

HEALTH PARTNERS PLANS MEMBERS ONLY

Full Name	*DOB*	*Gender*	*Dietary Restrictions*	*HPP Member ID*

NON-HEALTH PARTNERS MEMBERS

First Name ONLY	*Age*	*Dietary Restrictions if any -- DO NOT LIST DIAGNOSIS*