MEDICAL HOME COMMUNITY TEAM

REFERRAL FROM PROVIDER **FAX to: 215-731-6199**

Provider Information

Date of Referral:		**Medical Home Name:**			
Address:					
Primary Medical Home Contact:		**Title:**			
Contact Number:		**Email:**		**Fax Number:**	

Preferred Method of Contact (Check one):		Email		Phone		No Preference
Has an electronic version been submitted for this referral?		YES		NO		

Child Information

Please submit a separate referral form for each additional child connected to the medical home.

Last Name:						**First Name:**		
Date of Birth:		**Sex:**		Male		Female	**First Language:**	
Address:		**City:**		**Zip Code:**				

Race (Check all that apply):

	Black or African American		Native Hawaiian or Other Pacific Islander		Asian		Other / Unknown
	White		American Indian / Native Alaskan		Hispanic		

If Other / Unknown, please explain:	

Insurance Provider (Check one):

	Private Insurance		Public Insurance		No Coverage		Unknown

Primary Caregiver Information

Last Name:						**First Name:**	
Date of Birth:		**Sex:**		Male		Female	**Home Number:**	
First Language:		**Cell Number:**					

Race (Check all that apply):

	Black or African American		Native Hawaiian or Other Pacific Islander		Asian		Other / Unknown
	White		American Indian / Native Alaskan		Hispanic		

If Other / Unknown, please explain:	

Is this family aware that this referral is being made?		YES		NO	**If NO, please explain why below.**

Has the family signed off on the Authorization to Release Information Form?		YES		NO
Has this family been given a description of MHCT?		YES		NO
Is the family currently involved in any supportive family services?		YES		NO
If YES, please list all supportive family services below.				

Reason for Referral (Check all that apply)

	There are concerns for the client's physical, social, or emotional state		Your agency does not provide all the services that they need
	Assistance with child transitioning to adult practice		Linkages to community resources
	The client requested to be referred to MHCT or community programs		The client is transferring to another medical home and needs services
	Poor medical appointment follow-up/ needs help with care coordination		Concerns for the family safety or environment
	Caregiver-child conflict		Language barrier
	Caregiver with unmanaged physical or mental health challenges		Family needs health education
	Other	If Other, please list the reason for referral below.	

Child Diagnosis

What is/are the child's diagnosed special health care need(s) or risk(s) for special health care needs?

	Diagnoses (Check all that apply)	Notes
	No Diagnoses (N/A)	(Example: for any diagnosis checked, please note below the initial diagnosis date, the last time seen, etc.)
	Attention Deficit Disorder or Attention Deficit Hyperactive Disorder (ADD or ADHD)	
	A heart problem, including congenital heart disease	
	Allergies	
	Anxiety problems	
	Arthritis or other joint problems	
	Asthma or respiratory distress	
	At risk for special need	
	Autism Specturm Disorder or Social Communication Disorder	
	Behavioral or conduct problems	
	Blood problems such as anemia or sickle cell disease	
	Cancer	
	Cerebral Palsy	
	Cystic Fibrosis	
	Depression	
	Developmental delay	
	Diabetes	
	Down Syndrome	
	Epilepsy or seizure disorder	
	Failure to Thrive	
	Feeding problems	
	Head injury, concussion, or traumatic brain injury	
	Intellectual disability	
	Kidney Disease	
	Lead poisoning	
	Migraine or frequent headaches	
	Muscular Dystrophy	
	Obesity	
	Prematurity	
	Rare genetic disorder	
	Spina Bifida	
	Technology Dependent Child	

Explanation of Medical Goals Proposed for Your Client