Loretta's Little Miracles

Referral Form

Ph: (559) 226-1225 Fax: (559) 226-9014

Date: _____

Referred By: _____ **Ph:** _____

Child's Name: _____ **Age/DOB:** _____

Physician's Name: _____

Main Diagnosis: _____

☐ CP ☐ Shunt ☐ Seizures ☐ AUTISM/BEHAVIOR (Admit TBD)

Other Diagnoses: _____

_____

Care Needs: ☐ Trach ☐ GT/JT ☐ IV ☐ WC ☐ Cath ☐ Ostomy

☐ Monitor ☐ Oxygen Other: _____

Other: _____

MEDICATIONS: ☐ None ☐ 1x Day ☐ 2x Day ☐ 3x Day ☐ Many/Frequent Meds

TREATMENTS: ☐ None ☐ 1x Day ☐ 2x Day ☐ 3x Day ☐ Many/Frequent

INSURANCE: ☐ **Medi-Cal/ CalViva** ☐ **Private** ☐ **Other:** _____

SERVICES: ☐ **High Risk** ☐ **CCS** ☐ **School:** _____

☐ **CVRC** **Case Worker:** _____ **Ph:** _____

☐ **EPU/ Citi Kids/ Lori** **Case Worker:** _____ **Ph:** _____

☐ PT ☐ OT ☐ VI ☐ Speech ☐ Other: _____

☐ **CHCC: Rehab.** **Case Worker:** _____ **Ph:** _____

☐ PT ☐ OT ☐ VI ☐ Speech ☐ Other: _____

Parent/Guardian(s) _____

Phone: _____

Email: _____

Completed By: _____ **Date:** _____

OFFICE USE ONLY

PROCESS DATES 1st Call: _____ Tour: _____ Orientation: _____

Adm Paperwork: _____ Phys/TB: _____ Start Care: _____