



Loretta's Little Miracles



Referral Form

Please call (559) 226-1225 or complete and return form via fax (559) 226-9014

Date: _____

Referred By: _____

Ph: _____

Agency: _____

Admit TBD: AUTISM/BEHAVIOR: Danger to self/ others, Excessively Disruptive (in med. Fragile setting)

(to be reviewed by
Nursing Director)

Communicable/Contagious Condition(s) ex. MRSA, VRE, CMV, C-Diff, etc.

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

Parent/Guardian(s) _____ **Phone:** _____

Email: _____

Primary Physician: _____ Charlie Mitchell Clinic

Specialists: (GI, Endocrine, Neuro, Genetics) List MD name & Clinic: _____

Diagnosis(es): _____

CP Seizure Disorder Failure to Thrive

Nursing/ Medical GT/JT/NG Tracheostomy O2 Monitor Oxygen Catheter Ostomy

Needs: *Other:* _____

MEDICATIONS: None Few Many As Needed

If known, please list: _____

INSURANCE: Medi-Cal Private: _____ SSI CCS IHSS

SERVICES: HRIFC **Case Mgr:** _____ **Ph:** _____

CVRC **Case Mgr:** _____ **Ph:** _____

Public Health **Case Mgr:** _____ **Ph:** _____

EDUCATION: School: _____ Pre-K Special Day MTU

EPU CITI Kids Lori-Ann CHCC Rehab Dynamic Kid Other

PT _____ OT _____ VI _____ Speech _____ Other

Early Intervention Specialist: _____

CARE DAYS/HOURS M-F (7a-7p) **M:** _____ **T:** _____ **W:** _____ **Th:** _____ **F:** _____
REQUESTED: (10a-6p) **Sat:** _____ (9a-5p) **Sun:** _____

Other: _____

OFFICE USE ONLY

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

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