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): _____

Nursing/ Medical Needs:

☐ CP ☐ Seizure Disorder ☐ Failure to Thrive

☐ GT/JT/NG ☐ Tracheostomy ☐ O2 Monitor ☐ Oxygen ☐ Catheter ☐ Ostomy

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 REQUESTED:

M-F (7a-7p) ***M:*** _____ ***T:*** _____ ***W:*** _____ ***Th:*** _____ ***F:*** _____

(10a-6p) Sat: _____ ***(9a-5p) Sun:*** _____

Other: _____

OFFICE USE ONLY

PROCESS DATES

1st Call: _____ Tour: _____ Orientation: _____

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