CONFIDENTIAL

STARTS Physician Referral Form

Phone (800) 704-0900 **Fax to (408) 938-4536**

☐ *0-5 BX/MENTAL HEALTH* ☐ *0-5 DEVELOPMENTAL/BX PEDS* ☐ *AGE 6–18 BX/MENTAL HEALTH* ☐ *AGE 6–18 DEVELOPMENTAL/BX PEDS*
☐ *3-5 DEVELOPMENTAL/SPEECH & LANGUAGE (235 CONSENT FORM FOR VIA SERVICES NEEDS TO BE INCLUDED)*
** REFERRALS WITHOUT CLINIC NOTES &EMAIL ADDRESSES WILL NOT BE PROCESSED*

Referring Party Information	Name:_____ Phone: _____ Fax: _____ Email Required (print legibly): _____

PRIMARY CAREGIVER NAME:

☐ Parent ☐ Grandparent ☐ Other Relative_____

☐ Foster Parent (Please include name/phone of Social Worker)

_____

☐ Other (Please include relationship)_____

LEGAL GUARDIAN? ☐ Same

☐ NAME/PHONE IF NOT:_____

Primary LANGUAGE: ☐English ☐ Spanish ☐ Vietnamese ☐ Other:

_____(language) INTERPRETER NEEDED? ☐ Yes ☐ No

ETHNICITY: ☐ Asian ☐ Hispanic ☐ White ☐ Alaska Native or American Indian ☐ Multiracial ☐ Black/African American ☐ Other:

PRIMARY HEALTH CARE PROVIDER:
Name:_____ Phone:_____
Email Required (print legibly): _____

Apply VMC I.D. sticker if available

DATE: *(MM/DD/YY)*

CHILD NAME: DOB:
Gender: ☐ M ☐ F

Health Insurance ☐ Medi-Cal ☐ Healthy Kids ☐ Valley Health Plan ☐ Other:_____

Subscriber ID#:

Address_____

City _____ Zip _____

Home Phone # _____ Work # _____

Cell #_____

REASON FOR REFERRAL (REQUIRED - ATTACH CLINIC NOTES & SCREENING TOOLS WITH DESCRIPTION OF CONCERNS)
Has the child been previously screened? *Yes* ☐ No ☐ (*identify screening tool and attach results*)
Who has concerns? ☐ Parent ☐ Caregiver ☐ Teacher ☐ MD ☐ Other:

PREVIOUS OR SUSPECTED DIAGNOSES

PSYCHOTROPIC MEDS TRIED AND RESPONSE *(describe or attach clinic notes)* ☐ none

ADDITIONAL CHILD CONCERNS, RISK FACTORS AND BIOMEDICAL ISSUES *(mark all that apply & attach any School or Medical Subspecialty/Discharge records)*
☐ Fine Motor ☐ Gross Motor ☐ Speech/Language ☐ Social ☐ Severe Aggression ☐ Problem Solving/Cognitive ☐ Self-help/Adaptive ☐ Academics
☐ Prenatal Alcohol ☐ Prenatal Drugs ☐ NICU Grad. ☐ Chronic Disease ☐ Audiology ☐ Ophthalmology ☐ Genetics ☐ Other (include in clinic notes)

PREVIOUS & CURRENT SERVICES
☐ No Services ☐ Unknown ☐ Head Start/Preschool ☐ Early Start Program/IFSP ☐ Speech Therapy ☐ Physical Therapy ☐ Occupational Therapy
☐ SSI ☐ Special Ed/IEP ☐ 504 Plan ☐ SARC/IPP ☐ Mental Health ☐ Home Visitation ☐ Parenting Classes ☐ FIRST 5 Services ☐ Child Welfare
☐ Other (include in clinic notes)

ENVIRONMENTAL EXPOSURE/OTHER RISK FACTORS
☐ Alcohol ☐ Drugs ☐ Low Parental Education ☐ Teen Parent ☐ Parenting w/o Support ☐ Divorce ☐ Caregiver Mental Health ☐ Gang Involvement
☐ Domestic Violence ☐ Abuse ☐ Neglect ☐ Molestation ☐ Incarceration ☐ Other Court History (include in clinic notes) ☐ Other (include in clinic notes)

ADDITIONAL INFORMATION:
☐ Early Start Program/Date referral sent_____ ☐ Discussed School District/Special Education Services