CSHS Referral Intake Form

(Please attain all of the following Information)

Callers Name: _____ *Who took Call:* _____

Date: _____

Phone Number: _____

Referral: ☐ CSHS / South Central Region (Helena) ☐ Eastern Region Referral (Billings)

☐ Western Region Referral (Missoula) ☐ Other _____

Patient Name: _____ *DOB:* _____ *Gender:* _____

Mother Name: _____ *Father Name:* _____

Legal Guardian if different than above: _____

Address: _____ *City/State:* _____ *Zip:* _____

Home Number: _____ *Work Number:* _____

Message Number: _____ *Cell Phone:* _____

E-mail Address: _____

Health Coverage ☐ CHIP ☐ Children's Special Health Services ☐ Medicaid Pending

☐ Caring Program ☐ Self Pay ☐ Medicaid Spend Down

☐ IHS ☐ Medicaid ☐ Other _____

☐ Private Health Insurance Insurance Company Name: _____

Other Assistance Types: ☐ Social Security ☐ Children's Special Health Services

☐ Women Infants & Children Nutrition Program (WIC) ☐ Part C

☐ Other _____

CSHS Application Sent to Family? ☐ Yes ☐ No

Diagnosis: _____

Medications: _____ _____ _____

Allergies: _____ _____ _____

Medical Notes Requested? ☐ Yes, date requested _____

☐ No, Parent/Guardian will bring Medical Notes to Clinic

☐ Other _____

Physician: _____ *Specialist:* _____

Dentist: _____ *Orthodontist:* _____

Therapist: _____ *School* _____

Clinic Referral

Clinic Location: ☐ Billings ☐ Bozeman ☐ Browning ☐ Crow Agency ☐ Great Falls

☐ Helena ☐ Kalispell ☐ Missoula ☐ Wolf Point

Clinic Type: ☐ Cardiac ☐ Developmental ☐ Gastrointestinal ☐ Metabolic ☐ NICU

☐ Cerebral Palsy ☐ Down Syndrome ☐ Genetics ☐ MS ☐ Pulmonary

☐ Cleft/Craniofacial ☐ Diabetes ☐ Hemophilia ☐ Neurology ☐ Rehab

☐ Cystic Fibrosis ☐ Endocrine ☐ JRA ☐ Neuro Tube ☐ Rheumatology

Clinic Season: ☐ Winter ☐ Spring ☐ Summer ☐ Fall Year: _____

General Information: