

Care Coordination Referral Form

Date: _____ Child's name: _____ DOB: _____

Parent/Guardian: _____ Insurance: Medicaid ___ Chip ___ Other: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Work/Cell: _____ Language: _____

*As parent/guardian of the above named child, I understand that we are being referred to the **Integrated Services Program (ISP)**, part of the Bureau of Children with Special Health Care Needs at the Utah Department of Health. By signing below I authorize two-way communication and information sharing between the ISP and the referring physician/provider. I understand that this will include both demographic and pertinent clinical information.*

Signature (Parent/Guardian) _____ Date _____

Referring Physician/Provider Information

Clinic/Organization: _____ Name: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____

Diagnosis:

Reason for Referral:

This form is for coordination between the family, providers, schools, community programs, and Integrated Services Program. Thank you for choosing to refer your patient to us. To start the referral process, please fax this form to (801) 272-3502. By providing the information above, you agree that we may initiate contact with patient/family.



Integrated Services Program

Program Phone 801-273-2988 Program Fax 801-272-3502