Medical Referral / Confirmation

Date: _____ Check One: ☐ Referral ☐ Confirmation

Client's Name:		Date of Birth:	Social Security Number:
Medicaid #:	Medicaid Plan:	Primary Care Physician Name:	Contact #:
Child Advocate's Name:	Cell Phone #:	Supervisor's Name:	Cell Phone #:

Physician's Name:	Specialty:
Address:	Telephone:
	Fax:
Referring Person's Name:	Telephone:
Appointment Date & Time:	
Diagnosis/Reason for Referral:	

THIS SECTION TO BE COMPLETED BY MEDICAL PROFESSIONAL

Type of Visit Completed: (Please check one)

☐ **Well Baby Visit at age: (Please check one)**

☐ 1 month ☐ 2 months ☐ 4 months ☐ 6 months ☐ 9 months ☐ 12 months

☐ 15 months ☐ 18 months ☐ 24 months ☐ 30 months

☐ Annual Medical Exam ☐ Annual Dental ☐ Semi-Annual Dental ☐ Specialist ☐ Sick Visit

Physician's Assessment and Plan of Care:

☐ Follow-up Appointment	Date:	Time:	☐ AM ☐ PM
☐ Referral Given	Specialist:		
☐ Prescription			

Signature of MD / ARNP / RN	Date: