WHATCOM takingaction for Children and Youth with Special Health Care Needs (CYSHCN)

Child-Specific Information for Primary Care Provider

IMPORTANT:

You can either print this blank form and fill it out by hand to Fax to the PCP, or type in electronically, save a copy of the completed form in your electronic files, PRINT it and Fax it to the PCP. As noted in the letter below, also fax the PCP a copy of the SEAS Referral Form that you sent to SEAS, and a signed consent to exchange information form.

Date: _____

Dear: _____

Child's Name: _____ **DOB:** _____

I work with your patient, the child identified above, as his/her:

☐ Teacher ☐ School Nurse ☐ Preschool Teacher

☐ Childcare Provider ☐ Early Intervention Provider ☐ Therapist

☐ Mental Health Provider ☐ _____

Because of what I'm seeing with this child in our setting, I have concerns about:

☐ Autism ☐ Developmental condition ☐ Mental health condition

☐Need for specialty therapy: ☐Physical ☐Occupational ☐Speech/Language ☐Behavioral

☐ Unspecified ☐ _____

To explain the basis for my concerns, I've attached the following:

☐ Autism observation checklist ☐ Developmental screening ☐ Evaluation report

☐ Observational documentation ☐ _____

I have discussed my concerns with the child's parents. I've attached a signed consent allowing me to exchange information with you.

Since GIDES and/or specialty therapy services require a Primary Care Provider referral, if you, as the child's PCP, think it's appropriate to refer for either or both, please:

1. **Use the attached SEAS Fax Referral Form to make the referral, completing the GIDES and/or Specialty Therapy section(s) at the bottom of the SEAS form, AND**
2. **Fax the referral to SEAS at 360-676-6729**

Please contact me if you would like to discuss these concerns.

Thank you,

Referrer's Name: _____ Position: _____

Contact Information: _____