**South Coast Community Connections Network**

**(CCN)**

**Child Health Team**

# Referral Packet

Fax referrals to: Heather Garrett

FAX: 541.266.8466

Telephone: 541-269-0333 ext. 1237 or 541-808-4065

Please include all pertinent chart notes from Primary Care Providers, Specialists, Educational Service District screenings, school testing, etc.

Contact Information

Child/Youth Information

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Middle Initial: \_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_ / \_\_ / \_\_\_\_

Gender: ❑ M ❑ F ❑ Non Binary  
 ❑ Decline to Answer ❑ Other \_\_\_\_\_\_\_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
City: \_\_\_\_\_\_\_\_\_

Zip: \_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email

Parent/Guardian Information

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­­­­­­­­­­­­­­­­­­­­­­­­­­­

1. **Race: (Optional) Please check only one:**

❑ White ❑ Black or African American ❑ American Indian or Alaskan Native ❑ Asian

❑ Native Hawaiian or Pacific Islander ❑ Two or more races ❑ Unknown

1. **Ethnicity: (Optional) Please check only one**

❑ Hispanic ❑ Non-Hispanic ❑ Unknown

1. **Family’s Preferred Language:**  Spoken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Written: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Do you need an interpreter?** ❑ Yes ❑ No
3. **Does your child have a Primary Care Provider?** ❑ Yes ❑ No **If yes, indicate name:** ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(a regular family doctor, nurse practitioner or clinic)

1. **Does your child receive SSI (Social Security Income)?** ❑ Yes ❑ No
2. **Does your child have health insurance?** ❑ Yes ❑ No

If yes, indicate Primary Insurance Type: ❑ OHP Plus ❑ CAWEM ❑ Indian Health Services

❑ Private *(*please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Who referred your child to Community Connections Network?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Concerns

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Finances | Medical / Health | Access / Environment | Psychosocial | School / Education | Community Resources |
| * No concerns * SSI * Disability services * Health insurance coverage * Medical expenses after insurance * Household expenses covered * Food/clothing * Fuel/utilities * Housing * Respite expenses * Other: \_\_\_\_\_ | * No concerns * Access to primary care provider * Access to dental provider/care * Access to vision provider/care * Access to tertiary/specialty care provider * Communication with professionals * Coordination between providers * Health information * Medication use and side effects * Growth & development * Nutrition & feeding * Transition to adult health care * Other: \_\_\_\_\_\_\_ | * No concerns * Adaptive equipment such as feeding utensils, lifts, prone stander, walker * Manual wheelchair * Motorized wheelchair * Home modifications such as wheelchair ramps, doors * Transportation * Augmentative communication device * Computer/tablet * Other: \_\_\_\_\_ | * No concerns * Child behavior * Peer interactions * Emotional support * Parent/family support * Sibling support * Other: \_\_\_\_ | * No concerns * Early intervention * Special education * Tutoring * Vocational rehabilitation * Physical therapy * Speech therapy * Occupational therapy * Assistance teaching providers about health * Support with IFSP/IEP process * Support for transition process * Other: \_\_\_\_ | * No concerns * Recreation/ social interactions * Child care * Job training * Legal services * Summer/day camps * Respite * Other: \_\_\_\_ |

Parent Summary Form

Child's Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Caregiver:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source: Referral Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What questions/concerns would you like the team to address?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Share some of your child's strengths?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any other information about your child you want to share with the team?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Post School Outcomes

Where do you see your child at age?

16 yrs. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

20 yrs. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

25 yrs.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where would you like to see your child’s adult health?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What else would you like the doctor to know about your child?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Questionnaire

Child's Name: DOB: County:

Date Completed: Person Completing:

Primary Language: Relationship to Child:

|  |  |
| --- | --- |
| 1. Yes No  ❑ ❑ | Is your child on a special diet?  If yes, specify: |
| 2. Yes No  ❑ ❑ | Does your child require special feeding techniques or have difficulties with feeding (such as choking, gagging, coughing, vomiting, or slow to complete a meal)?  If yes, specify: |
| 3. Yes No  ❑ ❑ | Does your child have a history of neurological problems (such as seizures/epilepsy, muscle weakness, hydrocephalus or cerebral palsy)?  If yes, explain: |
| 4. Yes No  ❑ ❑ | Does your child have an orthopedic problem (such as scoliosis, hand or foot deformity, hip dislocation)?  If yes, specify: |
| 5. Yes No  ❑ ❑ | Does your child have a history of chronic illness (such as diabetes, asthma or kidney problem)?  If yes, specify: |
| 6. Yes No  ❑ ❑ | Has your child been hospitalized, had surgery or a serious injury?  If yes, explain: |
| 7. Yes No  ❑ ❑ | Does your child have a hearing problem or use a hearing aid?  If yes, explain: |
| 8. Yes No  ❑ ❑ | Does your child have vision problems or wear glasses?  If yes, explain: |
| 9. Yes No  ❑ ❑ | Does your child use adaptive equipment such as wheelchair, prone stander, or braces?  If yes, specify: |
| 10. Yes No  ❑ ❑ | Does your child need any other health treatments daily (such as gastrostomy feedings, intermittent catheterization)?  If yes, specify: |
| 11. Yes No  ❑ ❑ | List the medication(s) that your child takes: |

Brief Parental Self-Efficacy Scale

The Following are a few statements about you and your child. Please say how much you agree or disagree with each statement by placing an x in the column that best matches your feelings. There is no right/wrong answer.

Name of parent completing survey: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of completion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
| 1. Even though I may not always manage it, I know what I need to do with my child |  |  |  |  |  |
| 1. I can do the things that will improve my child’s behavior |  |  |  |  |  |
| 1. I can make an important difference to my child |  |  |  |  |  |
| 1. In most situations I know what I should do to ensure my child behaves |  |  |  |  |  |
| 1. The things I do make a difference to my child’s behavior |  |  |  |  |  |

List of Providers

Please list health and/or educational providers who have cared for your child in the past year so that we can request records. Examples include primary care physician, any specialists (neurologist, neurosurgeon, orthopedist, ophthalmologist, optometrist, ENT, urologist), teacher, physical therapist, speech pathologist, occupational therapist, public or home health nurse, school counselor, psychologist, advocate, etc. These providers may have valuable information to help in developing a plan for your child.

On the form to authorize release of information, please make sure these providers are listed if you want the records reviewed by the team.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Discipline**  **(Physician, Nurse, Educator, Therapist, etc)** | **Agency**  **(School, Hospital, etc.)** | **Date Last Seen**  **(if known)** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

RELEASE OF INFORMATION

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Coos Health and Wellness to: use the following information on my behalf for continuity of care and case management purposes:

□ Provide Information to: and/or □ Receive Information from:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Adapt |  |  | Kairos |
|  | Advanced Health |  |  | Kids HOPE Center |
|  | Attorney: |  |  | MOMS Program |
|  | Bay Area Hospital |  |  | ORCCA |
|  | Bay Cities Brokerage |  |  | Parent Child Representation Program |
|  | Behavioral Health: |  |  | Pathways to Positive Parenting |
|  | CDRC |  |  | School & District: |
|  | Coast Community Health |  |  | School Based Health Center |
| x | Community Connections Network |  |  | Social Security Administration |
|  | Community Living Case Management |  |  | South Coast ESD |
|  | Coos Health & Wellness |  |  | Supporting Transitions, Employment, and Progress (STEP) |
|  | Dental Care Provider: |  |  | Text exchanges between CHW and: |
|  | Dept. of Health & Human Services |  |  | Vision Provider: |
|  | Family Support and Connections |  |  | Vocational Rehabilitation |
|  | Family to Family |  |  | Waterfall Clinic |
|  | Head Start/Early Head Start |  |  | Working Wonders |
|  | Health Care Provider: |  |  | Other |
|  | Healthy Families Oregon |  |  | Other |
|  | Infant See |  |  | Other |

By initialing the spaces below, I specifically authorize the release of the following records:

\_\_\_\_ All hospital records

\_\_\_\_ Clinician office notes

\_\_\_\_ Drug/alcohol diagnosis, treatment, or referral information

\_\_\_\_ Home visiting records

\_\_\_\_ Behavioral health information

\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that use of this information for any other reason(s) than those designated by me is strictly prohibited, except in a medical emergency. Re-disclosure of this information may occur by another provider; however, re-disclosure is not allowed to an agent not indicated above without specific release to that agency or individual (ORS 197.505(14)).

This authorization is valid for □ six months or ⮽ until closure unless revoked in writing earlier. I understand that I can revoke this consent at any time, but also understand that the renovation will not affect any information that was released before the revocation. I understand that the information about my case is confidential and protected by state and federal law. I approve release of information as I have indicated in this consent. I understand what this agreement means, and that I will not be denied services by Coos Health and Wellness if I refuse to sign.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Witness Date

□ Client

□ Parent

□ Guardian/Legal Custodian

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Authorization to Use and/or Disclose Educational and Protected Health Information** | | | | |
| I authorize the following provider(s) to use and/or disclose educational and/or protected health information regarding my child: | | | | |
| Student’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Other names used by student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | School or program name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Name and address of health care provider authorized to:   * Send/disclose protected health information * Receive/use educational information * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Name and address of school/EI/ECSE program authorized to:   * Send/disclose educational information * Receive/use protected health information * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| I understand that this information will be used for the following purposes (check all that apply): | | | | |
| * Determining eligibility for Special Education, EI/ECSE, or other services   X Determining child/student’s current levels of performance  X Developing an individualized health plan | | * Developing an appropriate individualized education program or individualized family service plan   X Care Coordination/Case Management   * Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| By marking the boxes below, I authorize the use/disclosure of specific medical and/or educational records: | | | | |
| X Physician’s eligibility statement  X Health assessment statement  X History and physical exam   * Entire medical record * Prenatal information | X Educational information  X IFSP/IEP document   * Clinic records * Communicable disease(s) * Progress notes | | | X Psychological evaluations   * Social work reports   X Care coordination   * Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| By initialing the spaces below, I authorize the use/disclosure of the following information. Specific records requested MUST be listed below, e.g., assessment, treatment plan, and discharge plan. | | | | |
| * Drug/alcohol diagnosis, treatment or referral information requested * HIV/AIDS related records requested: * Mental health related information requested: * Genetic testing information requested: | | | | |
| I understand that:   * This authorization is voluntary and I may refuse to sign it without affecting my child’s health care * I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 § CFR 165.524). * I may revoke this authorization at any time by notifying \_\_\_\_\_\_\_ in writing. However, it will not affect any actions taken before the revocation was received or actions taken based on the previously shared information * Federal privacy rules for protected health information apply only to health plans, health care clearinghouses or health care providers. If I authorize disclosure of medical information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations. * Federal privacy rules for education information apply only to schools and EI/ECSE programs. If I authorize disclosure of educational information to other agencies or individuals the disclosed information may no longer be protected by federal  privacy regulations. | | | | |
| I consent to the use/disclosure of the above information. I understand that the use of this information for any reasons other than the expressed reasons stated above is prohibited. This consent is subject to revocation at any time, except to the extent that action has been taken based on information that has already been disclosed. | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of parent, legal guardian, student/child | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship | | |  | |
| This Authorization expires on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Not to exceed 1 year from date of signature, above | | | | |

Teacher’s Summary

Child's Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Teacher's Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Child’sDOB: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date Completed**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Comments/Concerns (Include issues you'd like the CCN team to address):

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Child's strengths:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Child's lagging skills:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Academic and/or classroom performance:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Health issues/concerns:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Academic and/or classroom performance:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Social/Behavioral concerns:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please return to:

*Heather Garrett*

*1750 Thompson Rd*

*Coos Bay OR 97420*

*541-269-0333 ext. 1237*

*541-269-5893 Fax*

Health Care Provider’s Summary

Child's Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Provider’s Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Child’sDOB: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date Completed**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Comments/Concerns (Include issues you'd like the CCN team to address):

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Health Concerns:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please return to:

*Heather Garrett*

*1750 Thompson Rd*

*Coos Bay OR 97420*

*541-269-0333 ext. 1237*

*541-269-5893 Fax*

Additional Provider’s Summary

Child's Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Provider’s Name/Discipline:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Child’sDOB: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date Completed**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Comments/Concerns (Include issues you'd like the CCN team to address):

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Behavioral/Health Concerns:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please return to:

*Heather Garrett*

*1750 Thompson Rd*

*Coos Bay OR 97420*

*541-269-0333 ext. 1237*

*541-269-5893 Fax*