**Coos County Child and Youth Services Universal Referral Form**Updated 11.30.2022

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please initial for requested service(s)\*:

\_\_\_ Advanced Health Confidential Fax: (541) 269-7147 Attn: Case Management

\_\_\_ Babies First (CH&W Public Health) Confidential Fax: (541) 888-8726 Attn: HV Program Mgr

\_\_\_ Bandon School District Confidential Fax: (541) 347-3974 Attn: Principal

\_\_\_ CaCoon (CH&W Public Health) Confidential Fax: (541) 888-8726 Attn: HV Program Mgr

\_\_\_ Children’s Program (CH&W Behavioral Health Confidential Fax: (541) 888-8726 Attn: Children’s Program Mgr

\_\_\_ Coastal Center Confidential Fax: (541) 267-5071; Phone: 541-267-2113

\_\_\_ Community Connections Network Confidential Fax: (541) 269-5893 Attn: CCN Coordinator

\_\_\_ Community Living Case Management Confidential Fax: (541) 266-7333 Attn: Eligibility Specialist

\_\_\_ Confederated Tribes of Coos, Lower Umpqua, Siuslaw Confidential Fax: (541) 888-1837 Attn: Tara Vrell

\_\_\_ Coos Bay School District Confidential Fax: (541) 269-6952 Attn: Director Special Programs

\_\_\_ Dental Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ The Devereaux Center Confidential Fax: 541-808-0940

\_\_\_ Early Head Start (Oregon Coast Community Action) Confidential Fax: (541) 888-2877 Attn: ERSEA Specialist

\_\_\_ Family to Family (OHSU) Confidential F2F Line: 1-503-494-3333

\_\_\_ Family Support and Connections (ORCCA) Confidential Fax: (541) 888-2877 Attn: Family Services Mgr

\_\_\_ Head Start (Oregon Coast Community Action) Confidential Fax: (541) 888-2877 Attn: ERSEA Specialist

\_\_\_ Intensive In-Home Behavioral Health Treatment Confidential Fax: (541.888.8726) Phone: 541.294.3028

\_\_\_ Kairos Confidential Fax (541) 267-3112 Attn: Access Specialist

\_\_\_ MOMS Program (Bay Area Hospital) Confidential Fax (541) 266-7893 Attn: MOMS Program

\_\_\_ Moms in Recovery (ADAPT) Confidential Fax: (541) 751-9985 Attn: Facilitator

\_\_\_ North Bend School District Confidential Fax: (541) 756-1313 Attn: Director Special Education

\_\_\_ North Bend Medical Center Confidential Fax (541) 266.4568 Attn: Pediatric Care Coordinator

\_\_\_ Parent Child Interaction Therapy (Behavioral Health) Confidential Fax: (541) 888-8726 Attn: PCIT Coordinator

\_\_\_ Pathways to Positive Parenting (SC ESD) e-mail securely to: [charityg@scesd.k12.or.us](mailto:charityg@scesd.k12.or.us)

\_\_\_ Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Powers School District Confidential Fax: (541) 439-2875 Attn: Administration

\_\_\_ South Coast Educational Services District Confidential Fax: (541) 266-4040 Attn: EI/ECSE

\_\_\_ South Coast Families First Confidential Fax: (541) 435-7768

\_\_\_ Vision Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ WIC: Women Infant Children (CH&W Public Health) Confidential Fax: (541) 888-8726 Attn: WIC Coordinator

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

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

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

Parent Name Birth Date Due Date (if pregnant) Youth’s Doctor

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

Youth’s Name Birth Date Race Youth’s Medical Card #

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

E-mail Address Phone Message Phone & Name

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

Physical Address Mailing Address

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

Referred By Program/Agency Phone/Extension E-mail Address

Narrative/Pertinent Information:

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

Follow up: (For use by program receiving referral)

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

**Completion of this side is optional based on need**

**Authorization to Use and/or Disclose Educational and Protected Health Information**

1. I authorize the following provider(s) to use and /or disclose educational and/or protected health information regarding me/my child:

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

(Name) (Date of Birth)

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

(Other Names Used) (School or Program Name)

Name and address of health care provider authorized to: Name and address of school/EI/ECSE program   
 authorized to:

Send/disclose protected health information Send/disclose educational information

Receive/use educational information Receive/use protected health information

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

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

2. I understand that this information will be used for the following purposes (check all that apply):

* Determining eligibility for Special education, EIIECSE, or other services
* Developing an individualized health plan
* Developing an appropriate Individualized Educational program or Individualized Family Service Plan
* Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. By marking the boxes below, I authorize the use/disclosure of the following specific medical and/or educational records:

* Physician’s Eligibility Statement
* Health Assessment Statement
* History and physical exam
* Entire medical record
* Prenatal information
* Educational information
* IFSP/IEP document
* Clinic records
* Communicable disease(s)
* Progress notes
* Psychological evaluations
* Social work reports
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. By initialing the spaces below, I authorize the use/disclosure of the following information. Specific records requests must be listed below, e.g., assessment, treatment plan, and discharge plan.

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

HIV/DIDS related records requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental health related information requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Genetic testing information requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. I understand that:

1. This authorization is voluntary and I may refuse to sign it without affecting my child’s health care.
2. I have the right to request a copy of this form after I sign it as well as inspect or copy and information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR 164.524).
3. 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.
4. 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.
5. 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.

6. 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 state above is prohibited. The 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.