



REFERRAL FOR PEDIATRIC SERVICES

Email address to send referrals to: HOME_VISITING_MCH@jacksoncounty.org

Today's Date _____

Public Health Service - MCH
140 S Holly St.
Medford, OR. 97501
Phone: 541-774-8209
Fax: 541-774-7977

Client: _____ Age: _____ DOB: _____

Housing: Last Name First Name MI
Living with Biological Parents Living with Extended Family Living with Foster Care

Parent/Guardian: _____ Age: _____ DOB: _____
Last Name First Name MI

Home Address: _____ 975 _____
Street Apartment City Zip Code

Mailing Address: _____

Telephone: _____ Alternate/ Message Phone: _____ E-mail: _____

Text: Yes No Primary Language: _____

Household/Family Roster: Age / Date of Birth: Living in Home
Income: Family Size

Client's PCP/Pediatrician: _____

PLEASE PROVIDE REASON FOR PEDIATRIC REFERRAL
Parent/Guardian notified of referral? Yes No
Medical Risk Factors:
Current Medications:
Current Equipment:
Behavioral Risk Factors:
Substance Exposure in Utero: Substances
Current Parental A&D Substance Abuse Current Parent Tobacco Use
Parent under the age of 16
Parental History of Mental Illness:
Parental History of Developmental Delay:
Parent with Limited Resources (Job, Finances, Home, Social Support)
Exposure to Domestic Violence/Child Abuse/Sexual Abuse
Other Pertinent Information: Gestational Age at Birth Wt. at Birth Length at Birth
NOTES:
(Use back if necessary)

OTHER REFERRAL INFORMATION PROVIDED TO PARENT/GUARDIAN:
WIC CaCoon PCP/Pediatrics DESD Other

REFERRAL SOURCE:
Agency/Program: _____ Phone: _____

Name: _____ Date: _____ Patient Label

ADDITIONAL PROGRESS/CLINICAL NOTES

| DATE | |
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OFFICE USE ONLY

| <u>Pediatric Referral Criteria</u> | <u>Priority</u> |
|---|--|
| Medical/Behavioral Risk Factors | |
| Babies First! (1 factor = 5 points; 2 factors = 10 points; 3 factors = 15 points) | ___ Points |
| CaCoon (Tier 1 = 5 points; Tier 2 = 10 points; Tier 3 = 15 points) | ___ Points |
| Social Risk Factors | ___ Points |
| (1 factor = 1 point; 2 factors = 2 points; 3 factors = 3 points) | |
| No PCP/Medical Home (2 Points) | ___ Points |
| No Insurance (2 points) | ___ Points |
| | Total Points: _____ |
| Priority Scoring: | |
| 1 st priority: 15+ Points | 2 nd priority: 10-14 Points |
| 3 rd priority: 6-9 Points | 4 th priority: 2-5 Points |

| | | |
|---|--|--|
| Client referred to: <input type="checkbox"/> CaCoon <input type="checkbox"/> Babies First! <input type="checkbox"/> DESD <input type="checkbox"/> Mental Health <input type="checkbox"/> PCP <input type="checkbox"/> WIC <input type="checkbox"/> Other _____ | Date Assigned: _____ Assigned to: _____ Does client have previous JCHHS Record? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date previously opened: _____ If yes, who was client previously assigned to? _____ | Client taken under care for this referral? <input type="checkbox"/> Yes - If yes, date: _____ <input type="checkbox"/> No - If no, NTUC Date: _____ <input type="checkbox"/> Parent/Guardian Declined Services <input type="checkbox"/> Staff Unable to Locate Client <input type="checkbox"/> NTUC due to priority scoring |
|---|--|--|

Revised May 2021

Patient Label