Care Connection for Children™
A partner in the Virginia children's special health needs network

Referral Worksheet

Date of Call: Assigned:
Date:

Referral Source			
Name/Title:		Phone #:	
Clinic/Organization:		Email:	
Patient Information			
Child's Name: Child's Birth date: Sex at Birth: ☐ Female ☐ Male ☐ Unknown Gender Identity/ Pronouns: Mailing Address: County:		Primary Diagnosis: Additional Diagnoses: MRN:	Hospital:
Parent/Guardian Name: Phone #: Email:	❑ Primary Contact	Ethnic Group: ❑ American Indian/Alaska Native ❑ Asian ❑ Black or African American ❑ Hispanic or Latino ❑ Native Hawaiian/ other Pacific Islander ❑ Other ❑ Unknown ❑ White ❑ More than one race reported	
Other Parent / Guardian Name: Phone #: Email:	❑ Primary Contact		
Preferred Language:		Interpreter needed : ☐ Yes ☐ No	
Family is aware of this referral: (Required) ☐ Yes ☐ No			
Emergency Contact:		Phone #:	
School:		Teacher's Name:	
Primary Care Physician:		Phone #:	
Physician Specialists:		Phone #:	
HEALTH CARE COVERAGE: FAMIS PLUS (Medicaid): FAMIS #:		❑ Aetna Better Health of Virginia ❑ Anthem Health Keepers Plus ❑ Optima/VA Premier/Sentara Family Care ❑ Molina ❑ United ❑ Fee-For-Service MCO #:	
COMMERCIAL COVERAGE: Insurance Member #: Insurance Group #:		Insurance provider: ❑ Aetna -- ❑ Anthem -- ❑ BC/BS -- ❑ Cigna -- ❑ Sentara -- ❑ United HealthCare Other:	
Identified Needs: ❑ Assistance with Insurance ❑ Case Management/Care Coordination		❑ Education Consultation/ School help ❑ Information/Referral to Community Resources	
Total # in Family:	# of Children:	# of Adults:	

(Required) **Information/Reason for Referral:**

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