



Children with Special Health Care Needs (CSHCN) Program Clark County Public Health

To make a referral, complete form and FAX to number below
FAX: 360.397.8442 or Call: 360.397.8440

***Note—Mandatory fields**

Date of Referral: _____
(MM/DD/YY)

*Referral Source: _____ * () _____
Name of Person/Agency making referral Referent's Phone #

*Child: _____ *DOB: _____ *Sex: M F
Last, First M mm/dd/yy

Race/Ethnicity: _____ Medicaid: Y N Assigned Plan _____

Social Security (SSI): Y N School Attending (if applicable) _____



*Parent(s) Name: _____

_____ City State Zip
Street Address/PO Box

_____ Phone # 1 Phone # 2

Parent(s) Informed of Referral: Y N Interpreter Needed: Y N Lang. _____

Child's Healthcare Provider/Specialists: _____

All Diagnoses: _____

Concern/Needs: _____

CSHCN Referral Form