



Help Me Grow  
Children's Trust Fund

## Medical Provider Referral Form

FAX to: 860-571-6853  
or call the Child Development Infoline at  
1-800-505-7000

Referring Medical Provider: \_\_\_\_\_ Date: \_\_\_\_\_  
Practice Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_ Fax: \_\_\_\_\_

### INFORMATION FOR REFERRAL

Child's Name: \_\_\_\_\_ M / F  
DOB: \_\_\_\_\_ Age in Months: \_\_\_\_\_ Gestational Age: \_\_\_\_\_  
Hospital of Birth: (optional) \_\_\_\_\_  
Child resides with: (name) \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Relationship: Parent / Legal Guardian / Foster Family Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Best time to call: (optional) \_\_\_\_\_ AM / Afternoon / Evening  
If family has no phone, contact person: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_ Best time to call: \_\_\_\_\_ AM / PM  
Primary language spoken in home: \_\_\_\_\_  
If not English, is there someone available who speaks English? Yes / No / Unknown  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

#### Reason for Referral:

Diagnosed Condition \_\_\_\_\_ ICD-9 code: \_\_\_\_\_

(OR)

Concerns about (check all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> motor            | <input type="checkbox"/> cognitive                  |
| <input type="checkbox"/> communication    | <input type="checkbox"/> adaptive                   |
| <input type="checkbox"/> social-emotional | <input type="checkbox"/> sensory: hearing or vision |
| <input type="checkbox"/> behavioral       | test results: _____                                 |

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Child's Health Plan Name: \_\_\_\_\_ Insurance Type: Commercial   
Insurance# /Medicaid #: \_\_\_\_\_ Medicaid

**Thank You!**