Southeast Regional Center
Children and Youth with
Special Health Care Needs

ADRC REFERRAL FORM

(Please Print)

REFERRAL SOURCE

Person:		ADRC:	
Today's date:	Phone:	Fax:	E-mail:

CLIENT INFORMATION

Client's last name:	First:	Middle	Gender: ☐ M ☐ F	Age:	Birth date: / /
Parent/Guardian Last name:		First:			
Street address:		City:			Zip Code:
Daytime phone: ☐ Preferred ( )	Evening phone: ☐ Preferred ( )	Cell phone ☐ Preferred ( )	E-mail: ☐ Preferred		

Primary language: ☐ English ☐ Spanish ☐ Other

☐ Contact Client rather than parent/guardian at phone: ( ) or email:_____

CLIENT NEEDS

☐ Does the client need help finding a primary care provider? Please describe:

☐ Does the client need help with health insurance? Please describe:

☐ Does the client need general transition information? Please describe:

☐ Does the client need help with services related to education, employment, or post-secondary education? Please describe:

☐ Other:

☐ Verbal permission granted to share client/parent's information with Southeast Regional Center.

Intake person's name: Date:

Contact the Regional Center

☐ Fax: 414-266-2225 ☐ Email: serc@chw.org ☐ Telephone: 414-266-6333

REGIONAL CENTER FOLLOW-UP

Thank your for the referral. We contacted the family and provided the following interventions:

Southeast Regional Center Staff *Phone* *Date*