REFERRAL TRACKING FORM

This form is designed to assist Children and Youth with Special Health Care Needs (CYSCHN) program staff in tracking referrals for services.

Instructions:

1. Complete all relevant sections for each referral.
2. Use one form per child/youth.
3. Update the **Actions Taken** and **Follow-Up/Status Updates** sections as new information becomes available.
4. When a referral is complete, fill out the **Closure Information** section.
5. Save and store the completed form securely, consistent with county data management policies.

REFERRAL INFORMATION

Date: _____
County: _____
Staff Name: _____

CHILD/YOUTH INFORMATION

Name: _____
Date of Birth: _____
Age: _____
Diagnosis/Condition: _____
Insurance Type: _____

Has Medical Home/Primary Care Provider (Y/N): _____

Name: _____

REASON FOR REFERRAL

SERVICES REQUESTED

☐ Care Coordination
☐ Family Support
☐ Transition Planning
☐ Medical Home Linkage
☐ Specialty Services
☐ Other: _____

ACTIONS TAKEN

Notes:

Outcome (accepted, pending, declined, etc.):

FOLLOW-UP / STATUS UPDATES

Date: _____

Summary of Next Steps: