



H-KISS FAX REFERRAL FORM

Please complete highlighted areas. If information is not available for some areas, you may skip.
H-KISS will follow up with the family. Thank you!

Disposition:

- Access
- Letter(s)
- Materials
- Staff: _____

From Name: _____ **Date:** ____/____/____

Office/Agency: _____ **Ph #:** _____

Address (if not parent): _____

Relationship to Child: Parent Pediatrician Other: _____

Child Name: _____ **Date of Birth:** ____/____/____

Gender: M F **Age:** ____ years ____ months

Area(s) of Concern: Cognitive Physical Communication Social/Emotional Adaptive

Concerns/Health Issues: _____

Screenings Done: ICMQ DIAL-R Denver CBCL B-ASQ HELP Audiological NBHS

Other: _____ **Significant Results (if any):** _____

Pediatrician: _____ **Ph #:** _____ **MD Specialist(s):** _____

Agencies Involved w/Child: CWS CSHN ECSP EIS PHN Guardian Ad-Litem

Healthy Start HomeReach Kaiser Kapi'olani Tripler WIC Other: _____

Parent Name(s): _____

Relationship to Child: mother father foster parent guardian other: _____

Residence Address: _____

Mailing Address (if different from above): _____

Ph# (h): _____ **(w):** _____ **(other):** _____ **Best time to call:** _____

Other School & Code: _____ **Complex & District:** _____

DOE 01/042 filed Child's Immunization Current Parent(s) have current TB clearance

ACTION (agency use only) ❖ Eligibility: Developmentally Delayed Biological Risk Environmental Risk

Referred To: Early Childhood Services Program (ECSP) PHN EIS Other: _____

Program Name: _____

Care Coordinator: _____ **Date Referred:** ____/____/____
(45 days: _____)