Medical Day Care Referral Form

This form is to be completed by parent/guardian of child. Please fill out both pages of this form as completely as possible, attaching documents as needed, so we can determine the appropriate level of care required.

Child's Name:	**Date of Birth:**	
Address:		
Allergies:	**Gender: Male Female**	**Race:**
Parent/Guardian Contact Information		
(1) Name: **Address (if different than child):** **Primary Phone:** **Secondary Phone:** **Email:**	**(2) Name:** **Address (if different than child):** **Primary Phone:** **Secondary Phone:** **Email:**	
Primary Care Physician **Name:** **Practice:** **Address:** **Phone:** **Fax:**	**Specialists** **(1) Name:** **Department:** **Phone:** **(2) Name:** **Department:** **Phone:**	
Primary Insurance: **ID#:**	**Secondary Insurance:** **ID#:**	
Medical Diagnoses:		
Medications:		
Health Care Needs:		
Diet:		
Therapy Services:		

Requested Days/Hours				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**

Comments:

Name of Referral Source (or nominee): _____

Signature: _____ **Date:** _____

Privacy Statement

Pediatric Specialty Care Medical Day at Danville collects personal information so as the program can plan and support the health care needs of your child. Without the provision of this information the quality of the health support provided may be affected. The information may be disclosed to relevant Pediatric Specialty Care Medical Day staff and appropriate medical personnel, including those engaged in providing health support as well as emergency personnel, where appropriate, or where authorized or required by another law. You are able to request access to the personal information that we hold about you/your child and to request that it be corrected.

Please see other side.