INTAKE FORM

Please send by:
Email: intake@rarekidsnetwork.org *or* Fax: (855) 588-7273

REFERRAL INFORMATION			
Name of Person Referring		Date	
Phone Number		Email	
Organization		Relationship to Client	
Is Family Aware of Referral?	☐ Yes ☐ No	Other Information	

CLIENT INFORMATION					
Child's Name					
Child's Date of Birth		Gender			
Mailing Address 1		Mailing Address 2			
City		State		Zip Code	
Home Phone #		Cell Phone #			
Mother's Name		Father's Name			
Primary Contact		Primary Language			

HEALTH INFORMATION			
Physician or Specialist		Phone #	
Insured?		Insurance Name	
Diagnosis			
Reason for Referral	☐ Care Coordination ☐ Education Consultation ☐ Information/Referral to Community Resources ☐ Assist with Insurance ☐ Other (describe):		

MEDICAL DOCUMENTATION (OPTIONAL)	
Please provide medical documentation of the diagnoses	☐ Copy of recent history/physical exam ☐ Encounter notes from specialty physicians ☐ Hospital discharge summary