

## Children's Volunteer Health Network, Inc. Referral Form

Last Name of Child \_\_\_\_\_ First Name \_\_\_\_\_ M \_\_\_\_ F \_\_\_\_

Age \_\_\_\_\_ DOB: \_\_\_\_\_ Race: W \_\_\_\_\_ B \_\_\_\_\_ H \_\_\_\_\_ Other \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

School: \_\_\_\_\_ School Grade: \_\_\_\_\_

Home Room Teacher's Name: \_\_\_\_\_

Name of Parents: Mother \_\_\_\_\_ Primary Language \_\_\_\_\_

Father \_\_\_\_\_ Primary Language \_\_\_\_\_

Name of Guardian: \_\_\_\_\_ Primary Language \_\_\_\_\_

IF Spanish is primary language, please list name &amp; number of an English speaking person (relative or friend) who we may contact to relay information: \_\_\_\_\_

Mother Place of Work \_\_\_\_\_ Phone \_\_\_\_\_

Father Place of Work \_\_\_\_\_ Phone \_\_\_\_\_

What services are you requesting from CVHN? \_\_\_\_\_ Dental \_\_\_\_\_ Medical \_\_\_\_\_ School Physical  
\_\_\_\_\_ Eye Exam \_\_\_\_\_ Counseling Other: \_\_\_\_\_

Describe your child's current symptoms: \_\_\_\_\_

Significant Medical History: \_\_\_\_\_ Allergies? \_\_\_\_\_

Current Medications: \_\_\_\_\_

Chronic Conditions : \_\_\_\_\_

Immunizations up to date? Yes \_\_\_\_ No \_\_\_\_ If No, what is needed? \_\_\_\_\_

Medicaid? Yes \_\_\_\_ No \_\_\_\_ Kid Care? Yes \_\_\_\_ No \_\_\_\_ Insurance?: Yes \_\_\_\_ No \_\_\_\_

Free/Reduced Lunch Program at school? Yes \_\_\_\_ No \_\_\_\_ Date of last physical: \_\_\_\_\_

Translator Needed? Yes \_\_\_\_ No \_\_\_\_ Transportation Needed? Yes \_\_\_\_ No \_\_\_\_

## Parent or Guardian Consent/Release

I give my consent for CVHN Doctor to provide evaluation and treatment for my child, \_\_\_\_\_, and understand that he/she is seeing my child free of charge this *one time only*. I understand that he/she will not become my child's permanent health care provider and is providing this care on this date only, unless otherwise specified by the doctor. I will arrange for follow-up care for my child through a clinic facility, or through arrangements with another physician at my own expense. I understand that this program does not cover hospitalization.

**Parent or Legal Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

A Children's Volunteer Health Network, Inc. volunteer has my permission to transport myself and/or my child to the appointment, **if needed**.

**Parent or Legal Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

I understand that CVHN is a registered non-profit charitable organization dedicated to helping children in need of health care. In giving my consent, I agree to hold harmless Children's Volunteer Health Network, Inc., its agents, administrators, staff and volunteers, and hereby release CVHN from all liability relating to or arising from any activities or services lawfully provided pursuant to this consent.

**Parent or Legal Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**CVHN Case Worker** \_\_\_\_\_ **Date** \_\_\_\_\_

**AUTHORIZATION FOR THE RELEASE  
OF HEALTH-RELATED INFORMATION  
(HIPAA-Compliant Form)**

\_\_\_\_\_  
**Name of Minor Child**

\_\_\_\_\_  
**Date of Birth**

I, \_\_\_\_\_, the Parent/Legal Guardian of the minor child named above, hereby authorize (1) any physician, health care professional, dentist, mental health counselor, hospital, clinic or other medical facility, laboratory, pharmacy, Federal or State agency offering medical benefits, and any other health care agency or organization that has provided treatment, services, or benefits to my child, and (2) any teachers, guidance counselors, school nurses, and any other employees of any school that my child has attended and whom have provided treatment, services or benefits to my child to disclose, give and release, without restriction, all of my child's individually identifiable health information and medical records regarding any past, present or future medical, dental or mental health condition, including all information related to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and drug or alcohol abuse to Children's Volunteer Health Network, Inc. ("CVHN"), its directors, officers, employees, volunteers and agents.

This authority given to any director, officer, employee, volunteer or agent of CVHN shall supersede any prior arrangement that I may have made, on my child's behalf, with my child's health-care providers to restrict access to or disclosure of my child's individually identifiable health information. The individually identifiable health information and other medical records given, disclosed or release to any director, officer, employee, volunteer or agent of CVHN may be subject to redisclosure by such director, officer, employee, volunteer or agent of CVHN and may no longer be protected by HIPAA. The authority given to any director, officer, employee, volunteer or agent of CVHN herein has no expiration date and shall expire only in the event that I revoke this HIPAA Release in writing and deliver it to my child's health-care provider. There are no exceptions to my right to revoke this HIPAA Release on behalf of my child.

**Date** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Parent/Legal Guardian**

**Date** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Witness**

P.O. Box 2142  
Santa Rosa Beach, FL 32459  
850-622-3200 Fax: 850-622-5434

Dear Parent/Guardian and Client,

As the founder of Children's Volunteer Health Network, I want to welcome you and explain our program. As a faith based organization, we feel it is our privilege to serve and meet the needs of the uninsured and under-insured children in our area. We also believe, it is a partnership with our healthcare providers, and you as a recipient of those services benefiting your child. We all need to work together to make this a successful experience for everyone involved.

**We have promised our *healthcare professionals* that we will do the following:**

- CVHN will make and confirm all appointments with the providers.
- We will have all required paperwork filled out accurately and fully.
- We will follow up with the provider to make sure that all expectations were met from them, as well as the patients.
- On initial visits, we will send a volunteer with the parent/guardian and child to facilitate the visit.
- Unless requested by the provider, each appointment is a *one time only visit*.

**As a recipient of these benefits, we require you to:**

- Never be late for an appointment or not show up. This has a disastrous ripple effect on the entire program.
- Be courteous and polite to the providers and staff. Ask your child to do the same. Ungracious and rude behavior is not acceptable.
- If you feel you have a suggestion or an idea, please express it to the caseworker or director, ***not the provider***. Positive feedback makes us all better.

If you agree with these terms, then please sign at the bottom of this page. Have your child sign below your name.

**Parent/Guardian** \_\_\_\_\_

**Client/child** \_\_\_\_\_

*Our children are the hearts and future of this community.  
They are our most precious resource.  
Let's work together to keep these kids happy and healthy!*

May God Bless you,



Tricia Carlisle Northcutt

P.O. Box 2142  
Santa Rosa Beach, FL 32459  
850-622-3200 Fax: 850-622-5434

**\*\*\*TO BE COMPLETED BY ATTENDING DOCTOR/COUNSELOR\*\*\***

HEALTH CARE PROVIDER: Please fill in the areas below.

Fax the **completed form**, along with a **Walk Out Statement\*** indicating the charges that *would have* been incurred with a **“NO CHARGE”** notation to 850-622-5434.

If immediate follow-up is needed (i.e. medication, further tests),  
Please call our office at 850-622-3200.

**Findings/Diagnosis** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Recommendations** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Referred to** \_\_\_\_\_

**Primary Reason for Referral** \_\_\_\_\_

**Next Appointment:**    **Date** \_\_\_\_\_                      **Time** \_\_\_\_\_

**Signed by Doctor/Counselor** \_\_\_\_\_                      **Date** \_\_\_\_\_

Unless otherwise specified by your recommendation and/or referral,  
this is a one-time only appointment. If any follow-up appointments are needed, it is important that CVHN be notified of each additional visit, along with the corresponding treatment plan.

\*A detailed report listing all procedures performed and fees the patient would have been charged.