HealthPlan OF SAN MATEO
Healthy is for everyone

801 Gateway Blvd., Suite 100 | South San Francisco, CA 94080

Pediatric Care Coordination Referral Form

Please fax this completed form with any pertinent health records to **650-829-2047.**
To speak with HPSM Care Coordination or refer by phone, please call **650-616-2060.**
To request health education materials for your patient, please call **650-616-2165**.

Referral Date

REFERRING PRACTITIONER OR FACILITY

Name: First MI Last Title:

Phone: Fax: Email:

Was the parent or legal guardian informed of this referral? ◯ Yes ◯ No

MEMBER INFORMATION

Members Name: First MI Last

DOB: Gender: ◯ Male ◯ Female

Member ID#:

Phone: Language:

HPSM Plan: ◯ Healthy Kids ◯ HPSM Medi-Cal

Parent/Legal Guardian Name:

Parent/Legal Guardian Phone:

Street Address: City, State Zip:

PCP: name of members primary care physician Phone: Fax:

Specialist: name of specialist, if applicable. Phone: Fax:

Diagnosis(s):

Patient's preferred therapy day: Patient's preferred therapy time:

Therapy Provider's next available appointment:

Is Patient currently receiving therapy (i.e. through the school district)? Please specify.

Brief description why member is being referred:

All referrals are evaluated for eligibility criteria before program admission. In all programs, patient confidentiality is observed at all times. **Please transmit with a confidential fax cover sheet.**

OFFICE USE ONLY

PROCESSED BY: RECEIVED: SENT: