# Oregon Department of Human Services logoCIIS Medically Fragile Children’s Unit Program Referral Form

Child’s name:

DOB:

Parent name(s):

Address:

City:       State:       Zip:

Mailing address *if different*:

Phone:       Work:       Cell:

Email:

Language spoken in the home: [ ]  English [ ]  Other:

Medicaid #:       Social Security number:

Primary physician:       Phone:

Diagnosis:

## Referral information

Date of referral:

[x]  Medically Fragile Children’s Unit

Does the family know they are being referred to us? [ ]  Yes [ ]  No

Name of referral source:       Phone number:

## County information

County name:

Case manager's name:      Phone:

## General information

Has DD eligibility been established at the county? [ ]  Yes\* [ ]  No\* [ ]  Pending

*\*Please attach a copy of the current DD eligibility statement and all copies of case management documents CIIS requires for each referral. Intakes will not be processed without these documents.*

The child currently resides:

[ ]  Family home [ ]  Nursing facility [ ]  Foster care [ ]  Other

## Other known agencies or programs involved with family/child

Is child receiving SSI? [ ]  Yes [ ]  No

[ ]  CAF [ ]  SDSD [ ]  CACOON [ ]  EI/ECSE [ ]  OAC

[ ]  Private insurance [ ]  Other:

Please list specific information about other agencies such as name of worker, phone number, and specific services, if known:

## Family information

Private insurance:

Phone number:

## Presenting medical issues (Check all conditions that apply)

[ ]  Ventilator:

[ ]  Trach:

[ ]  G Tube:

[ ]  Seizures:

[ ]  Oxygen:

[ ]  Has child had 911 code/resuscitation in last year? [ ]  Yes [ ]  No

Other presenting issues:

## Hospital referral

Hospital referral: [ ]  Yes [ ]  No Discharge date:

Nursing agency contacted: [ ]  Yes [ ]  No

Name of agency contacted:

## Recommendations

Recommend formal intake: [ ]  Yes [ ]  No

Intake given to:

Medically Fragile Children’s Unit criteria score:      Date:

## Follow up

[ ]  Opened for services Service coordinator:

[ ]  Referred out

Waiver filled out: [ ]  Yes [ ]  No

Children’s Medical Project (CMP) paperwork completed: [ ]  Yes [ ]  No

## Submit completed referral forms by email or FAX

**Email:** ciis.referrals@odhsoha.oregon.gov

**FAX:** 971-673-2971

**Questions?** 971-673-2285

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Children’s Intensive In-Home Services (CIIS) at ciis.referrals@odhsoha.oregon.gov or 971-673-3000 (voice/text). We accept all relay calls.