



10602 Chapman Ave, Suite 101 • Garden Grove, CA 92840 • Tel 714-532-7942 • Fax 714-532-7945

A) Information/Información **LOG Entry Date**

Date/Fecha	Child's Name/Nombre del Niño:	Date of Birth/Fecha de Nacimiento:	School/Escuela
Parent/Guardian, Padre/Guardián:		Telephone #/Teléfono:	Primary Language/Idioma
Address/Domicilio:	City/Ciudad:	Zip Code/Código:	
Any children under 5/Tiene niños debajo de 5 años? Yes/Sí <input type="checkbox"/> How Many/Cuántos _____ No <input type="checkbox"/>		Type of Health Insurance/Tipo de Seguro Médico:	

B) Authorization/Autorización

Parent/Guardian or Responsible Person's Authorization: I hereby consent to an exchange of confidential information between BOYS & GIRLS CLUBS OF GARDEN GROVE/CHOC CLINIC AT GARDEN GROVE/HEALTHY SMILES FOR KIDS OF ORANGE COUNTY/SOUTHERN CALIFORNIA COLLEGE OF OPTOMETRY/FACT OC FRCs and _____ concerning my child/self in order to enhance the treatment and follow-up of the condition for which this referral is made.

La Autorización del Padre/Guardián o Persona Responsable: Consentimiento para intercambiar información confidencial de mi niño o sí mismo entre BOYS & GIRLS CLUBS OF GARDEN GROVE/CHOC CLINIC AT GARDEN GROVE/HEALTHY SMILES FOR KIDS OF ORANGE COUNTY/SOUTHERN CALIFORNIA COLLEGE OF OPTOMETRY/FACT OC FRCs para aumentar el tratamiento y la medida complementaria de la condición de que está referido.

Parent/Guardian or Responsible Person's Signature: _____ **Date:** _____
Firma del Padre/Guardián o Persona Responsable *Fecha*

C) Service Requested —OFFICE USE ONLY **REPEAT USER yes no**

Basic Needs	Family Services	Health Services	Community Services	Other
<input type="checkbox"/> Clothing/Toiletries <input type="checkbox"/> Employment <input type="checkbox"/> Food <input type="checkbox"/> Housing/Shelter <input type="checkbox"/> Transportation	<input type="checkbox"/> After-school <input type="checkbox"/> Childcare/Preschool <input type="checkbox"/> Educational <input type="checkbox"/> ESL <input type="checkbox"/> Parenting Classes	<input type="checkbox"/> Counseling 0-5 <input type="checkbox"/> Counseling 6-18 <input type="checkbox"/> Counseling Adults <input type="checkbox"/> Dental <input type="checkbox"/> Insurance <input type="checkbox"/> Medical Care <input type="checkbox"/> Vision Care	<input type="checkbox"/> Legal Services <input type="checkbox"/> Tax Assistance <input type="checkbox"/> Citizenship <input type="checkbox"/> Sports	_____ _____

Referred By: _____ Phone #: _____ Fax #: _____

Notes: _____

D) Referral—OFFICE USE ONLY **ETO Entry Date** **CASE CLOSED DATE**

Name of Agency: _____ Phone #: _____

Name of Agency: _____ Phone #: _____