



714-532-7940 • Fax 714-532-7945



Children's Hospital of Orange County
Garden Grove Clinic

714-532-7900 • Fax 714-532-7912



Healthy Smiles
For Kids of Orange County

714-532-7935 • Fax 714-532-7931

Collaborative Client Referral Form

Date/Fecha ____/____/____	Child's Last Name/Apellido del Niño:	Child's First Name/Nombre del Niño:	Date of Birth/Fecha de Nacimiento:
Parent/Guardian, Padre/Guardián:	Telephone #/Número de Teléfono:	Cellphone #/Número de Celular:	
Address/Domicilio:	City/Cuidad:	Zip Code/Código:	
Primary Language/Idioma English __ Español __ Vietnamese __	Best time to call/La hora mejor para llamar:	Type of Health Insurance/Tipo de Seguro Médico:	

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/HUMAN OPTIONS and _____ concerning _____ (Referring Agency) 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/HUMAN OPTIONS y _____, para aumentar el tratamiento y la medida complementaria de la condición de que está referido. _____ (Agencia de Referencia)

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

For Office Use Only/Para uso de la Oficina	**Please check where form faxed to:
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Boys & Girls Clubs of Garden Grove <input type="checkbox"/>	CHOC Clinic <input type="checkbox"/>	Healthy Smiles for Kids of OC <input type="checkbox"/>
<input type="checkbox"/> After-School Programs <input type="checkbox"/> Basic Needs <input type="checkbox"/> Counseling <input type="checkbox"/> Community Services <input type="checkbox"/> County Services <input type="checkbox"/> Education Services <input type="checkbox"/> English-Language Classes <input type="checkbox"/> Parent Child Interactive Therapy <input type="checkbox"/> Transportation <input type="checkbox"/> Vision Care	<input type="checkbox"/> Case Management <input type="checkbox"/> Health Education <input type="checkbox"/> Healthy Families <input type="checkbox"/> Immunizations <input type="checkbox"/> Physical <input type="checkbox"/> Preventative Care <input type="checkbox"/> Sick Care <input type="checkbox"/> Specialty Referral <input type="checkbox"/> WIC Referral	<input type="checkbox"/> Dental Care <input type="checkbox"/> SmileLineOC Referral <input type="checkbox"/> Oral Education - Toothfairy Learning Center

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

Date: ____/____/____ **Notes:** _____

Receiving Individual: _____ **Phone #:** _____ **Follow-up Date:** ____/____/____

Notes: _____

Referred To: _____ **Phone #:** _____ **Fax #:** _____

Referred To: _____ **Phone #:** _____ **Fax #:** _____