

Connector Service Program Referral Form

Please complete this form and e-mail to pchicctreferral@imail.org or fax to 801-662-6723

Referral Guidelines

1. Patient's age must be 0 to 17.
2. Patient must have three or more complex, chronic illnesses.
3. Patient must not be actively working with care managers in Hem/Onc, Cystic Fibrosis, Spina Bifida, Transplant, or University of Utah Neurobehavior HOME Clinic.
4. Patient's home location must be in catchment area (all of Salt Lake County and southern portions of Davis County).

Patient Information

Patient Name

Date of Birth (dd/mm/yyyy)

Patient MRN

Preferred Language

Parent/Guardian Name & Relationship to Patient

Residence within catchment?
(See Referral Guidelines above)

Yes No

Phone Number

Text messages okay?

Yes No

Referral Information

Connector Service Program has been introduced to the family, and they are agreeable to us contacting them? *(Please note, family will only be contacted if/when we are going to enroll into the program)*

Yes No

Who is referring this patient?

Referring Providers Phone Number/E-Mail

Reason for Referral? (Brief medical/social history. How will the Connector Service benefit this family?)

If you are aware of any specific needs of the patient or their immediate family, please document them below. If unsure, okay to leave all options blank.

Access to Healthy Food

Housing/Safe Living Conditions

Assistance Paying Utility Bills

Adult Education/Employment Services

Health/Dental Insurance

Public Benefits (SNAP, WIC, SSI/SSDI)

Educational Support for Child/Child-Related Activities

Need for Car Seat, Diapers, Clothing, Other Supplies or Items

Help with Legal Issues (Immigration, Divorce, Custody, etc.)

Transportation to Appointments and/or Other Services

Addiction and/or Psychological Services

Safety Concerns Related to Violence or Abuse

Other

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