

LOCAL HEALTH SERVICES REQUEST

Date: _____
 To: _____
 Attention: _____
 Address: _____
 City/State/Zip: _____
 Phone () _____ - _____

Client Name: _____
 Address: _____
 City/State/Zip: _____
 County: _____

Caregiver/Emergency Contact: _____
 Relationship: _____ Phone # _____

MA# _____ Private Ins. None
 Birthdate ___/___/___ SS# _____-____-_____
 Sex: M F Hispanic: Y N
 Race: (circle) Afr-Amer/Black; Alaskan Native; Amer Native;
 Asian; More than one race; Native Hawaiian; or Pacific Islander;
 Unknown; White
 Marital Status (circle) Single Married Unk
 If Interpreter is needed specify language: _____

FOLLOW-UP FOR: (Check all that apply)
 Child under 2 years of age
 Child 2 - 21 years of age
 Child with special health care needs
 Pregnant EDD: ___/___/___
 Adult with disability (mental, physical, or developmental)
 Substance abuse care needed
 Homeless (at-risk)

Diagnosis: _____

Comments: _____

MCO
 From: _____ MCO
 Date Received: ___/___/___
 Document Outreach:
 Letter(s) _____
 Phone Call(s) _____
 Face to Face _____
 Unable to Locate
 Contact Date ___/___/___
 Advised _____ Refused
 Comments: _____

 Contact Person _____
 Telephone # _____
 Fax # _____
 Provider Name: _____
 Provider Phone # _____

RELATED TO: (Check all that apply)
 Missed appointments: ___ # missed
 Adherence to plan of care
 Immunization delay
 Preventable hospitalization
 Transportation
 Other

LOCAL HEALTH DEPARTMENT (COUNTY)
 Date Received: ___/___/___
 No Action (returned)
 Reason for return: _____
 Documented Outreach: _____
 Letter(s): _____
 Phone Call(s): _____
 Face to Face: _____
 Disposition: _____
 Contact Complete: Date ___/___/___
 Unable to Locate: Date ___/___/___
 Referred to: _____ Date ___/___/___
 Contact Person: _____
 Telephone # _____ Date ___/___/___

Comments: _____

