REFERRAL

Oakland County Health Division
Children's Special Health Care Services

(Send referral via encrypted email to cshcs@oakgov.com or fax to 248-452-2195)

Agency Contact	Agency Name
Agency Phone	Agency Fax
Child's First Name	Last Name
Address:	Email:

DOB:	☐ M ☐ F	☐ Parent/Guardian aware of referral

Parent Contact Name	Phone
Parent Contact Name	Phone

REASON FOR REFERRAL	
☐ Child with severe, chronic, medical condition who sees a specialist	
Type of Specialist:	Name of Specialist:
Medical Diagnosis:	
☐ Client is in school Special Education program	

Needs Assistance:

- ☐ Completing CSHCS application
- ☐ Completing prior authorization requests
- ☐ Paying medical bills
- ☐ Paying for medications
- ☐ Paying for/procuring durable medical equipment
- ☐ Paying for mileage/transportation
- ☐ Other:

Needs:

- ☐ Care Coordination
- ☐ Case Management
- ☐ Information about private duty nursing
- ☐ Information about respite care
- ☐ Information/Assistance with out of state providers
- ☐ Community resources
  - Type: _____
  - Type: _____
- ☐ Assistance with Children's Waiver or TEFRA
- ☐ Information/Assistance applying for Children's Special Needs Fund
- ☐ Other: