



KHC Referral/Service Plan

FAX TO KHC: (313) 659-3298

PHONE: (313) 863-2427

Date of Referral _____ *Month/Day/Year*

Practice/Clinic/Partner Name _____

Practice/Partner telephone number _____

Child's Name _____ DOB _____

Parent/Guardian _____

Address 1 _____

Address 2 _____

City _____

Primary Phone Number _____

Secondary Phone Number _____

Client Medicaid ID Number _____ Medicaid Health Plan _____

Referring Primary Care Provider or Partner Name _____

(For community agencies/schools or partners only):
I have spoken to parent about KHC and they agree to allow KHC to contact them
_____ Yes _____ No

I - ASTHMA	
Request KHC Interventions:	
<input type="checkbox"/> KHC Asthma Case Management (MATCH) Education	
<input type="checkbox"/> Care coordination with school	
<input type="checkbox"/> Other _____	
FOR:	
1. _____ Newly diagnosed asthma	
2. _____ Assistance implementing management plan	
3. _____ Interference with activity/school/family life	
4. _____ Inappropriate use of ER/urgent care/rescue medications	

II- BEHAVIORAL HEALTH ISSUES-CHILD

Request KHC Interventions:

- Educate family on issues/management
- Enroll family in FitFamilies Healthy Minds

Assist to obtain

- Evaluation/Work up
- Management Plan
- Treatment

Facilitate coordination with

- School
- Specialty care
- Other _____

Link family to

- Community resources
- Information/Education
- Support Services

FOR:

- ADD/ADHD
- Cognitive Impairment/Learning Disability
- FAS/FAE

Developmental Delay - ASQ:

- Yes
- No

Other Mental Health Problems

- Anxiety Disorder
- Autism
- Depression
- Eating Disorder

Sensory deficits

- Visual
- Hearing
- Other _____

Substance use

- Tobacco
- Alcohol
- Drugs Type
- Other _____

III - BEHAVIORAL HEALTH ISSUES - PARENT

Assist with referrals for

- Evaluation
- Treatment
- Cognitive impairment
- Domestic Violence
- Mental Health Problem

Substance use

- Tobacco
- Alcohol
- Drugs _____

IV - ER USAGE

Request KHC Education/Support Interventions for:

- Child has inappropriately used ER 1-2 times within last 6 months
- Child has inappropriately used ER 3 or times within last 6 months
- Dates/Diagnoses_____

V - MISSED VISITS/WELL CHILD CARE

Request KHC Education/Support Interventions for:

- Child has missed 2 or more scheduled appointments within last 6 months
- Child has missed most recent scheduled well child visit for age group
- Child is behind on immunizations for age group
- Child needs to be seen ASAP for _____

VI - WEIGHT CONCERNS

Request KHC Education/Support Interventions for:

- Nutrition Education
- Link to Community resources

Fitkids 360

- I certify this child is cleared for participation in the FitKids program

PCP Name_____

First Name_____ Last Name_____

Signature_____

- BMI between 70th - 84th percentile
- BMI between 85th - 94th percentile
- BMI at or above 95th percentile

VII - OTHER

Request KHC Education/Support Interventions for:

- Meeting basic needs
- Accessing Community resources

COMMENTS