Special Kids ♥ Special Care Referral Form

DATE _____

Child's Name: _____ DOB: _____ Sex:

MassHealth ID: Number: _____

Diagnoses: _____

_____

_____

_____

Primary Care Physician/ Name of Practice: _____

Phone Number: _____ Fax Number: _____

Mailing Address:
Street: _____ City _____ Zip _____

Child is: New Patient ☐ Current Patient ☐ If new patient, has the physician seen the child? Yes ☐ No ☐

Foster Parent/Group Facility Information:

Name(s) _____

Street _____ City _____ Zip ___

Telephone: Home _____ Work _____

DCF Information: DCF Office: _____ Fax: _____

Caseworker: _____ Telephone: _____

Supervisor: _____ Telephone: _____

Regional Nurse: _____ Telephone: _____

Contracted Agency (if applicable): _____

Contracted Agency Worker**:** _____ Telephone: _____

Prepared by: Name _____ Telephone _____

********* NOTE: If this referral is being submitted by DCF staff, please also submit a copy of the current Mittimus.**

Please fax this form to either: Deborah Titelbaum at 617-847-3475 and DCF Medical Services at 617-261-7437.

Questions can be directed to: Deborah Titelbaum, MassHealth Nurse Manager, at 617-847-3497; or Mary Lutz, DCF Director of Medical Services, at 617-748-2358.

HEALTH AND HUMAN SERVICES PROVIDERS

PHYSICIANS

NAME	SPECIALTY	TELEPHONE

HOSPITALS

NAME	EMERGENCIES or SPECIALTY CARE?	TELEPHONE

EARLY INTERVENTION PROVIDER

CONTACT PERSON	AGENCY	TELEPHONE

HOME CARE PROVIDERS

CONTACT PERSON	AGENCY	TELEPHONE

MEDICAL EQUIPMENT COMPANIES

CONTACT PERSON	VENDOR	TELEPHONE

BEHAVIORAL HEALTH PROVIDERS

NAME	AGENCY	TELEPHONE

OTHER STATE AGENCIES (E.G., DMR, MCB)

CONTACT PERSON	AGENCY	TELEPHONE