



Oregon Center for Children and
Youth with Special Health Needs
(OCCYSHN)

Community Connections Network:

*linking health, education and community services through a network of
community-based teams*

Community Connections Network

Referral Packet

**HOOD RIVER COUNTY COMMUNITY CONNECTIONS NETWORK (CCN)
AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION**

Child's Name	DOB	SCHOOL
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Parent/Guardian	Address	City	Zip
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The purpose of this authorization form is to enable agencies identified as members of the Community Connections Network to better serve your child through coordinated service planning and delivery. Representatives of these agencies will meet and share information regarding your child at scheduled clinics, planning and team meetings.

The Community Connections Network may include the following agencies:

Hood River County School District
 Hood River County Health Department
 Hood River Community Connections Team
 Primary Care Provider
 (please specify doctor or clinic) _____
 OHSU

Additional Specialists:

- _____
- _____
- _____

Signing this form indicates consent for the following information to be exchanged:

- **Medical and/or related health records**
- **Official student academic/administrative records (IEP, Section 504 plan)**
- **Educational Multidisciplinary team evaluations and related reports**
- **Psychiatric or Psychological Evaluation(s)**
- **Reports from any agency listed above**
- **Discussion/Consultation between members of above agencies around care coordination**
- **CCN Assessment Summary; and CCN Physician report if generated**

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my initials in the applicable space next to the type of information.

_____ **HIV/AIDS information** _____ **Genetic testing information**

This release authorizes a mutual exchange of information between agencies in order to give the most complete and thorough services available. It does not authorize the release to any other person or agency except those agencies listed above. Unless revoked in writing, this release and exchange of information shall remain in force for a period of 12 months.

Initials	Signature of Parent, Legal Guardian	Date
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Name of person obtaining parent's signature _____

Please Return Records to:
 Hood River CCN Attn: **Yolanda Mora**
 1109 June Street
 Hood River, OR 97031
Or Fax at: 541-386-9181



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PARENT SUMMARY FORM

Child's Name: _____ Parent: _____

DOB: _____ Date Completed: _____

Referral Source: _____ Referral Reason:

What questions/concerns would you like the team to address?

Share some of your child's strengths?

Is there any other information about your child you want to share with the Clinic team?

Please return to:

Coordinator's name
Community Connections Coordinator
Address
City

over → Family Concerns

FAMILY CONCERNS

* Check all that apply. It may not be possible for the team to address and solve all family concerns, however it is helpful to know areas of concern.

FINANCES	MEDICAL / HEALTH	ACCESS / ENVIRONMENT	PSYCHOSOCIAL	SCHOOL / EDUCATION	COMMUNITY RESOURCES
<input type="checkbox"/> No Concerns <input type="checkbox"/> SSI <input type="checkbox"/> Disability services <input type="checkbox"/> Health insurance coverage <input type="checkbox"/> Medical expenses after insurance <input type="checkbox"/> Household expenses covered <input type="checkbox"/> Food/clothing <input type="checkbox"/> Fuel/utilities <input type="checkbox"/> Housing <input type="checkbox"/> Respite expenses <input type="checkbox"/> Other _____	<input type="checkbox"/> No Concerns <input type="checkbox"/> Access to Primary Care Physician <input type="checkbox"/> Access to dental care <input type="checkbox"/> Access to specialty care for condition <input type="checkbox"/> Communication with professionals <input type="checkbox"/> Coordination between providers <input type="checkbox"/> Health information <input type="checkbox"/> Medication use and side effects <input type="checkbox"/> Growth & development <input type="checkbox"/> Nutrition & feeding <input type="checkbox"/> Other _____	<input type="checkbox"/> No Concerns <input type="checkbox"/> Adaptive equipment such as feeding utensils, lifts, prone stander, walker <input type="checkbox"/> Manual wheelchair <input type="checkbox"/> Motorized wheelchair <input type="checkbox"/> Home modifications such as wheelchair ramps, doors <input type="checkbox"/> Transportation <input type="checkbox"/> Augmentative communication device <input type="checkbox"/> Other _____	<input type="checkbox"/> No Concerns <input type="checkbox"/> Child behavior <input type="checkbox"/> Peer interactions <input type="checkbox"/> Emotional support <input type="checkbox"/> Parent/family support <input type="checkbox"/> Sibling support <input type="checkbox"/> Other _____	<input type="checkbox"/> No Concerns <input type="checkbox"/> Early Intervention <input type="checkbox"/> Special education <input type="checkbox"/> Tutoring <input type="checkbox"/> Voc. rehabilitation <input type="checkbox"/> Physical therapy <input type="checkbox"/> Speech therapy <input type="checkbox"/> Occupational therapy <input type="checkbox"/> Assistance teaching providers about health <input type="checkbox"/> Support with IFSP/IEP Process <input type="checkbox"/> Support for transition process <input type="checkbox"/> Other _____	<input type="checkbox"/> No Concerns <input type="checkbox"/> Recreation / social interactions <input type="checkbox"/> Child care <input type="checkbox"/> Job training <input type="checkbox"/> Legal services <input type="checkbox"/> Summer/day camps <input type="checkbox"/> Respite <input type="checkbox"/> Other _____

over → Parent Summary



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TEACHER'S SUMMARY

Child's Name: _____ Teacher's Name: _____

DOB: _____ Date Completed: _____

Comments/Concerns (Include issues you'd like the CCN team to address):

Child's strengths:

Child's weaknesses:

Academic and/or classroom performance:

Health issues:

Social/Behavioral Concerns:

Please return to:

Coordinator's name
Community Connections Network Coordinator
Address

City



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PHYSICIAN'S SUMMARY

Child's Name: _____ **Teacher's Name:** _____

D.O.B.: _____ **Date Completed:** _____

Comments/Concerns (Include issues you'd like the CCN team to address):

Health Concerns:

Please return to:

Coordinator's name

Community Connections Network Coordinator

Address

City



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HEALTH QUESTIONNAIRE

Child's Name: _____ **DOB:** _____ **County:** _____
Date Completed: _____ **Person Completing:** _____
Primary Language: _____ **Relationship to Child:** _____

1. Yes No Is your child on a special diet?
If yes, specify _____
2. Yes No Does your child require special feeding techniques or have difficulties with feeding (such as choking, gagging, coughing, vomiting, or slow to complete a meal)?
If yes, specify: _____
3. Yes No Does your child have a history of neurological problems (such as seizures/epilepsy, muscle weakness, hydrocephalus or cerebral palsy)?
If yes, explain: _____
4. Yes No Does your child have an orthopedic problem (such as scoliosis, hand or foot deformity, hip dislocation)?
If yes, specify: _____
5. Yes No Does your child have a history of chronic illness (such as diabetes, asthma or kidney problem)?
If yes, specify: _____
6. Yes No Has your child been hospitalized, had surgery or a serious injury?
If yes, explain: _____
7. Yes No Does your child have a hearing problem or use a hearing aid?
If yes, explain: _____
8. Yes No Does your child have vision problems or wear glasses?
If yes, explain: _____
9. Yes No Does your child use adaptive equipment such as wheelchair, prone stander, or braces?
If yes, specify: _____
10. Yes No Does your child need any other health treatments daily (such as gastrostomy feedings, intermittent catheterization)?
If yes, specify: _____
11. Yes No List the medication(s) that your child takes: _____

What else do you think the doctor needs to know about your child? _____



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PATIENT CONTACT INFORMATION

Child's Name _____ **DOB** _____ **Sex** male female
***Ethnicity:** Black Hispanic Asian/Pacific Islander American Indian/Alaskan Native White Unknown

Preferred Languages Spoken _____ **Interpreter Used** _____
Preferred Languages Written _____

Parent/Guardian _____

Address _____ **City** _____ **Zip** _____

Phone _____

Primary Care Provider _____

Referral Source _____

Insurance Information No Insurance **SSI** yes no

Plan 1 _____ (company name & phone)
 Circle: OHP Other

Plan 2 _____ (company name & phone)
 Circle: OHP Other

Subscriber's Name _____ **Relationship to Patient** _____

**** OPTIONAL**