Kidango Behavioral Health Referral Form

Important Reminders:

****To help us maintain confidentiality per HIPAA, referral must be faxed, delivered in person or mailed to:***

Kidango Behavioral Health Dept.

44000 Old Warm Springs Blvd., Fremont, CA 945383

****Alameda County Fax#: 510-440-1200 / Santa Clara County Fax#: 510-493-7743***

Do NOT email form unless authorized by program manager.

Referral Information:

Referral Date: / / Phone: _____

Referred by: _____ E-mail: _____

Agency/Location: _____

Client Preferred Language: _____ Parent Preferred Language:_____

Client Information:

Last Name: _____ Medi-Cal #: 9 _ _ _ _ _ _ _ _ _

First Name: _____ (must be 8 digits long and starts with a "9")

Middle: _____ If no Medi-Cal, indicate insurance information below:

Birthdate: / / M____ F____

Parent/Guardian Information:

Parent/Guardian #1: _____ Phone#: _____

Address: _____

Signature: _____

Parent/Guardian #2: _____ Phone#: _____

Address: _____

Signature: _____

Concerns:

Provide a *brief* description of concerns below:

_____

_____

_____

_____

_____

_____

_____

_____

** To avoid delays, please fill out form completely. Use one form per child.*

To inquire on status, call our intake specialists:* ***Alameda County, 510-656-3949 opt. 5 or Santa Clara County, 408-315-6612*