Kidango Behavioral Health Referral Form

Important Reminders:

****To help us maintain confidentiality per HIPAA, referral must be faxed, delivered in a sealed envelope via inner-office mail or mailed to:***

Kidango Behavioral Health Dept.

44000 Old Warm Springs Blvd., Fremont, CA 94538

****Alameda County Fax#: 510-509-1670/ Santa Clara County Fax#: 510-509-1670***

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: _____

First Name: _____

Middle: _____

Birthdate: / / M____F____

Medi-Cal #: _____

(must be 8 digits long and starts with a "9")

If no Medi-Cal, indicate insurance information below:

Parent/Guardian Information:

Parent/Guardian #1: _____

Phone#: _____

Address: _____

Signature: _____

Parent/Guardian #2: _____

Phone#: _____

Address: _____

Signature: _____

Concerns:

Please Mark All Concerns that Apply:

Hitting/Aggressive Behavior		Fighting		Speech Concerns	
Defiant Behaviors		Social Interaction Concerns		Learning Concerns	
Disruptive		Difficulty Sharing		Motor Concerns	
Destroys Things		Screaming/Excessive Crying		Other Concerns:	
Tantrums		Trauma (experience/exposure)			

Additional Comments:

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

To inquire on status, call our intake specialists:* ***Alameda County, 510-585-9815 or Santa Clara County, 408-200-2912*