Kidango Behavioral Health Referral Form

Important Reminders:

To help us maintain confidentiality per HIPAA, referral may only be delivered via: secure email to gina.meredith@kidango.org, faxed, delivered in a sealed envelope via inner-office mail (Kidango internal), or mailed to:

Kidango Behavioral Health Dept.

Attention: Gina Meredith

777 N. First Street, Suite 220, San Jose, CA 95112

****Alameda County Fax#: 510-440-1200/ Santa Clara County Fax#: 408-293-1000***

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: _____

Parent/Guardian #2: _____ Phone#: _____

Address: _____

Child Currently Resides With:

☐ Biological Parents	☐ Biological Parents Separated (Shared Custody)	☐ Biological Parent (single parent is primary caregiver)	☐ Foster Parent
☐ Legal Guardian	☐ Adoptive Parent	☐ Other:	

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)			

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

For program questions and/or to inquire about your referral, call our Program Manager, Gina Meredith, LCSW at 408-605-3816.