Kidango Behavioral Health Referral Form

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#: 510-670-2839/ Santa Clara County Fax#: 408-291-1000***

Do NOT email form.

Referral Information:

Referral Date: / /	Received Date: / /
Referred by:	Agency:
Phone:	Email:
Client Preferred Language:	Parent Preferred Language:

Client Information:

*The information requested below is **REQUIRED** in order to process your referral in a timely manner.*

Last Name:	First & Middle Name:
Birthdate: / /	Gender (M/F):
Birth County:	Birth State:
Birth Country:	**Medi-Cal #: 9**__ __ __ __ __ __ __ *(Active full-scope Medi-Cal required to receive services)*

Ethnicity (check one): A. White ☐ C. Native American ☐ F. Vietnamese ☐ L. Other Non- White ☐
B. Black ☐ E. Chinese ☐ K. Other Asian ☐ M. Unknown ☐

Parent/Guardian Information:

Parent/Guardian #1	**Parent/Guardian #2**
Name:	Name:
Address:	Address:
Phone#:	Phone#:

Office Use Only:

Medi-Cal: YES NO **AWARDS**: YES NO **INSYST**: YES NO *(If yes, note client number below & update info*)*

Returning Client? ☐

***Client/Insyst ID:** ___ ___ ___ ___ ___ ___ ___ ___ **Insyst Face Sheet** (printed/scanned/uploaded) Yes ☐ No ☐

Timeliness Report Complete: Yes _____ No____ Date submitted to Clinical Supervisor: / /

Intake Specialist Comments/Notes:

** 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*