High Risk Pediatric Clinic at Clinica Sierra Vista
Referral Form

Please complete and fax to 661-617-2881

Patient name:

DOB:

Parent/caregiver name:

Contact phone number:

Reason for referral:

Referred by:

Current primary care doctor:

Is the child currently a CSV patient?

Medical Diagnoses (please list):

Which specialists are involved in the child's medical care team?

Does the child have any technology dependence (ex.Tracheostomy, G-tube, Oxygen, CPAP)?

Does the child need assistance with daily activities (ex.bathing, mobility)?

What social services is the child receiving (ex. In home nursing, respite care, SSI)?