



# UNIVERSAL HEALTH CARE REFERRAL FORM

Help Me Grow Western New York (HMG) is a free referral service that connects parents and providers to information about child development and community resources. By completing this form, you provide consent to:

- ❖ receive free information from HMG on child development and community resources in your area;
- ❖ receive access to a free developmental tracking tool called the Ages and Stages Questionnaire (ASQ) for each of your children ages 5 and younger;
- ❖ allow exchange of information between HMG, the provider named below, and their community partner organizations. These organizations offer services you may choose to use in supporting the well-being, health, and development of the child(ren) listed below.

<b>Provider's Information</b>	<b>Provider Name (e.g. Agency, Practice, School Name):</b> _____ <b>Contact Person:</b> _____ Street: _____ City: _____ Zip Code: _____ Phone: _____ Fax: _____ Email: _____
<b>Family's Information</b>	<b>Parent / Guardian Name(s):</b> _____ Street: _____ City: _____ Zip Code: _____ Home Phone: _____ Cell Phone: _____ Email: _____ <b>Best time to contact:</b> <input type="checkbox"/> Between ____ AM/PM and ____ AM/PM <input type="checkbox"/> After 5pm <input type="checkbox"/> Anytime <b>Best form of contact:</b> <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email <input type="checkbox"/> Text my Cell Phone <b>Please contact me in:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please include specific dialect): _____ <b>Child Name:</b> _____ <input type="checkbox"/> Male <input type="checkbox"/> Female <b>Date of Birth:</b> ____/____/____ <b>Premature?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, # of weeks early: _____ <b>Concerns/Reason for Referral:</b> _____ <b>Existing services and/or other referrals in progress:</b> _____ <input type="checkbox"/> Please ask me about my other children when you contact me.

By signing this form, I, the parent/legal guardian, authorize the release and use of the information above. I also give permission to HMG, the provider listed above, and their partner service organizations to exchange information about the developmental and resource information being provided to my family.

\_\_\_\_\_  
Original Signature of the Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Original Signature of Person Completing This Form

\_\_\_\_\_  
Date

To SUBMIT this form, fill in the blanks, print and sign. Email (gsmith@hmgwny.org) or fax (716.822.5577) to Gerald Smith, Family Resource Coordinator. Call 2-1-1 & press 7 with any questions.