COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Kid Connections
Consultation & Assessment Collaborative for Children & Families

FIRST 5 SANTA CLARA COUNTY

# STARTS Referral Form

Behavioral Health Call Center: **Phone:** (800) 704-0900**, Fax:** (408) 947-5848 **Email:** KCN.Referral@hhs.sccgov.org

**1. REFERRAL SOURCE**

| Referring Agency / School: | Program Name / District: | Referring Person: |
|---|---|---|
| Referring Person's Phone: | | Referring Person's Email: |
| Reason for Referral *(please explain on additional paper if more room is needed):* | | |

**2.** PRIMARY CAREGIVER INFORMATION

| Full Name: | Relationship: ☐ Parent ☐ Grandparent ☐ Foster Parent ☐ Other: _____ Legal guardian? ☐ Same ☐ Name, if not: _____ | Gender F ☐ M ☐ |
|---|---|---|
| Ethnicity: *(mark one)* ☐ Asian ☐ Hispanic ☐ Alaska Native or American Indian ☐ Multiracial ☐ White ☐ Black/African American ☐ Other: | Primary Language: *(mark one)* ☐ English ☐ Spanish ☐ Vietnamese ☐ Other: | |
| Address: _____ City: Zip: | Home Phone: Work Phone: Cell Phone: | Best time to call: |

3. REFERRED CHILD INFORMATION *(age 0-5 years only)*

| Full Name: Sibling/Siblings referred: ☐ Yes ☐ No | DOB: (MM/DD/YY) | Gender: F ☐ M ☐ | Check if child has: ☐ FSP ☐ IEP ☐ N/A or UK |
|---|---|---|---|
| Ethnicity: *(mark one)* ☐ Asian ☐ Hispanic ☐ Alaska Native or American Indian ☐ Multiracial ☐ White ☐ Black/African American ☐ Other: | | Primary Language: *(mark one)* ☐ English ☐ Spanish ☐ Vietnamese ☐ Other: | |
| 3A. CHILD'S HEALTH INSURANCE: ☐ No Insurance ☐ Medi-Cal ☐ Healthy Kids ☐ Valley Health Plan ☐ Other: **Health Insurance ID #:** **Primary Care Physician Name** *(IF AVAILABLE):* | | | |
| **Referring for Triple P?** ☐ Y ☐ N **If YES, what level?** ☐ L2 ☐ L3 ☐ L4 ☐ L5 ☐ Unknown or Not Sure | | | |
| 3B. CHILD CONCERNS AND RISK FACTORS: ***(including concerns of caregivers and/or teachers)*** *(mark all that apply)* ☐ None/Unknown ☐ Fine Motor ☐ Gross Motor ☐ Speech/Language ☐ Problem Solving/Cognitive ☐ Severe Aggression ☐ Social ☐ Self-help/Adaptive ☐ Academics ☐ Prenatal Alcohol ☐ Prenatal Drugs ☐ NICU Grad ☐ Feeding Issues ☐ Sleep Issues ☐ Other: | | | |

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3C. FAMILY CONCERNS AND RISK FACTORS:

☐ None/Unknown ☐ Alcohol ☐ Drugs ☐ Low Parental Education ☐ Teen Parent ☐ Single Parent
☐ Neglect ☐ Abuse ☐ Domestic Violence ☐ Gang Involvement ☐ Caregiver Mental Health ☐ Molestation
☐ CPS history ☐ Divorce ☐ Incarceration ☐ Other Court History: ☐ Other:

3D. PREVIOUS & CURRENT SERVICES:

☐ No Services ☐ Triple P**, Level:** ☐ Head Start/Preschool ☐ SARC/IPP ☐ Speech Therapy
☐ Physical Therapy ☐ Occupational Therapy ☐ Special Ed/IEP ☐ 504 Plan ☐ Early Start Program/IFSP
☐ Mental Health ☐ Home Visitation ☐ Parenting Classes ☐ SSI
☐ FIRST 5 Supports: ☐ Other:

3E. Referral Comments and Specific Concerns: *(please provide additional information on behavioral concerns, or additional information as needed)*

4. Additional Comments, Notes, Information: *(preferred agency)*

**Please include the following with referral: 1) KidConnections Referral Cover Sheet, 2) KidConnections STARTS Referral Form, 3) ASQ-3 and ASQ:SE 2 Summary Sheet, and 4) other information that would be relevant to referral.**

**Referrals cannot not be processed when referral is incomplete or missing information. Please ensure STARTS form and attachments are included to support timely referral processing.**