CLINICAL CONTACT FORM

TYPE OF CARE REQUESTED: **□RESPITE** **□TRANSITIONAL** **□END OF LIFE**

DATES REQUESTED: ________________________________ TO ________________________________

CONTACT NAME/AGENCY: ____

PHONE NUMBER:____

CHILD"S NAME: ____
FIRST M LAST

DATE OF BIRTH: ______________________________ GENDER: ______________________________

DIAGNOSIS: ____

PRIMARY PHYSICIAN: _________________________________ PHONE NUMBER: __________________

____
INSURANCE CARRIER I.D./POLICY#

PLEASE COMPLETE BELOW FOR RESPITE SERVICES

____
REGIONAL CENTER I.D.#

____
REGIONAL CENTER CASE WORKER PHONE NUMBER

FAX YOUR COMPLETED FORM TO: KATHY LEE, ADMISSIONS CASE MANAGER AT 510.346.4620 OR EMAIL DIRECTLY TO: ADMISSIONS@GEORGEMARK.ORG

RESPITE REFERRALS WILL RECEIVE A REPLY WITHIN 48 HOURS OF SUBMISSION.

REFERRALS RECEIVED ON FRIDAYS WILL RECEIVE A REPLY THE FOLLOWING MONDAY.