HELP ME CALIFORNIA Grow
SAN MATEO COUNTY
Resources to Thrive from 0-5

REFERRAL FORM

PLEASE RETURN FORM TO:
HELP ME GROW SAN MATEO COUNTY
Email: hmgsmc@gatepath.org | Fax: 650-603-0326

FOR OFFICE USE ONLY
Date received: ____________
Assigned to: ____________
Date assigned: ____________

PARENT/CAREGIVER INFORMATION

Parent or Guardian's First and Last Name: ______________________________

Primary Phone: ____________________ Alternate Phone: ____________________

Email: ______________________________

Primary Language: ☐ English ☐ Spanish ☐ Other ____________________

Best time to reach parent(s): ☐ Morning ☐ Afternoon ☐ Evening

CHILD'S INFORMATION

Date of Birth (MM/DD/YY) ____________________ Gender: ☐ M ☐ F

First Name: ____________________ Last Name: ____________________

Address: ______________________________

City, State ____________________ Zip Code____________________

Was child born premature? ☐ Yes, number of weeks________ ☐ No ☐ I don't know

Child's Primary Care Physician: ______________________________

Child's Insurance Provider: ______________________________

REFERRING PROVIDER

Is the family aware of this referral: ☐ Yes ☐ No

Name of Person Making Referral: ______________________________

Referring Organization: ______________________________

Phone Number: ____________________ Fax Number: ____________________

Email: ______________________________

REASON FOR REFERRAL (PLEASE CHECK ALL THAT APPLY):

☐ Parent's Questions/Concerns about child development ☐ Community Resources ☐ ASQ Developmental Screening

Additional Information: ______________________________

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☐ I agree to have a staff member of Help Me Grow contact me and send me information on services and programs for my child.