Help Me Grow Nebraska

Provider Referral Form

*Required Field

Provider Information:

*Name of Organization or Clinic: _____

*Contact Person: First Name: _____ Last Name: _____

*Street: _____ *City: _____ *State: NE *Zip: _____

*Phone: _____ Fax: _____ Email: _____

*Is this family receiving services from your office? Yes ◯ No ◯

*Are you the Primary Care Provider(PCP)? Yes ◯ No ◯

If no, please provide:

PCP: First Name: _____ Last Name: _____

Name of Organization or Clinic: _____

Street: _____ City: _____ State: NE Zip: _____

Phone: _____ Fax: _____ Email: _____

Parent/Guardian Information:

*First Name: _____ *Last Name: _____

*Street: _____ *City: _____ *State: NE *Zip: _____

*Home Phone: _____ *Cell Phone: _____

Work Phone: _____ Email: _____

Preferred language: English ◯ Spanish ◯ Other ◯ _____

Accessibility or Accommodation Needs (e.g. hearing impaired): _____

Child Information (Each Child must be referred individually):

*First Name: _____ Middle Initial: ____*Last Name: _____

*What sex was your child assigned at birth(e.g. on your birth certificate):

Female ◯ Male ◯ Intersex ◯ Prefer not to answer ◯

*Date of Birth(MM/DD/YYYY): _____

***What are the concerns or reasons for referral? Check all that apply.**

Basic Needs ☐ Behavioral Concerns ☐ Child Development Concerns ☐

Educational Concerns ☐ Known Disabilities ☐ Speech/Communication ☐

☐ Other: _____

Additional Provider Notes:_____

_____

*Have development screening tools been completed? Yes ◯ No ◯

Please list completed screening tools if known: _____

_____

Name of the child's health plan: _____

Type of insurance the child has:

Private/Commercial ◯ Medicaid ◯ Both ◯ Unknown ◯

How did you hear about Help Me Grow? Choose all that apply.

Community Agency ☐ Community Event ☐ Family/Friend ☐ Flyer ☐

HMG In-Service ☐ Hospital ☐ Internet ☐ Social Media ☐

☐ Other: _____

By making this referral to Help Me Grow (HMG), you acknowledge that the family has given permission for HMG to contact them, share their child's developmental screening results, and provide care coordination to assist the family in accessing needed resources or referral linkages.

Has the family provided verbal consent?

Yes, they have agreed ☐

You may submit this form to HMGNE@UWMidlands.org, fax it to 402-522-7984 or call Help Me Grow at 2-1-1 or 402-444-6666 and select Option 2.