Scott County Health Department
Care for Kids Referral Form

Referral Date: _____ Referred by: _____
(ie. Medical provider, school nurse, social worker)

Whom may we contact at your office if we have questions about the referral?

Name: _____ Phone: _____

Child's Name:	Parent/Guardian's Name:
Telephone:	Address:
List any known communication and/or transportation barriers:	
Reason for Referral or Care Coordination services needed: □ Medical/Dental/Vision Home □ Care Coordination (i.e. set appointments, reminder calls, connect with transportation, etc.) □ Developmental Concerns □ Linking to Health Insurance □ Other:	
Notes:	
To make a referral: Call: **563-328-4114** Fax completed form to: **563-326-8774** Securely email: **health@scottcountyiowa.com**	

Revised: December 2018