Multnomah County
Health Department

Intensive Care Coordination Request Form

Referral contact information:

Referred by:_____ Agency/role: _____

Phone:_____ Fax:_____ Email:_____

Youth Information:

Youth Name:_____ Date of birth: _____ Gender:_____

Race/ethnicity: _____ Tribal Affiliation:_____

Oregon Health Plan (circle one): Yes No OHP number (if yes):_____

Secondary Insurance:_____

Primary Language:_____

Address: _____

Legal guardian name:_____

Phone:_____ Fax:_____ Email:_____

Guardian address (if different):_____

System supports:

Current school: _____ Grade: _____

School contact: _____ Individualized Education Program: Yes No

Phone:_____ Fax:_____ Email:_____

Primary care provider:

Phone:_____ Fax:_____ Email:_____

Mental health provider:

Phone:_____ Fax:_____ Email:_____

Other involved support:_____

Phone:_____ Fax:_____ Email:_____

Other involved support:_____

Phone:_____ Fax:_____ Email:_____

Department of Human Services Guardianship (circle one): Yes No Guardianship date: _____