

**Kentucky Family to Family Health Information Center**  
**Commission for Children with Special Health Care Needs**  
**UofL Pediatrics – General Pediatrics**

**Referred Parent Intake Form**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_  
(Last Name) (First Name)

Address \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_

Home Telephone \_\_\_\_-\_\_\_\_-\_\_\_\_ Cell \_\_\_\_-\_\_\_\_-\_\_\_\_ Best Time to call \_\_\_\_\_

Work Telephone \_\_\_\_-\_\_\_\_-\_\_\_\_ Email \_\_\_\_\_

Referred by: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Provider \_\_\_\_\_ Routine Visit Site \_\_\_\_\_

**Child with Special Needs Information**

Name \_\_\_\_\_, \_\_\_\_\_ DOB \_\_\_\_-\_\_\_\_-\_\_\_\_ Age \_\_\_\_  
(Last Name) (First Name)

Gender M ☐ F ☐

When Diagnosed? ☐ Before Birth ☐ At Birth ☐ At Age of: \_\_\_\_

Primary Diagnosis/Details \_\_\_\_\_

Secondary Diagnosis/Details \_\_\_\_\_

**Release of Information**

I give permission to the **Kentucky Family to Family Health Information Center** to share my name, phone number, name of my child, birth date and diagnosis with a Support Parent.

Parent Signature \_\_\_\_\_

Fax referral to:

Laura Jean Wood Perez  
Phone: 502-588- 0704  
Fax: 502-588-0701

If you have additional questions, please feel free to contact:

Debbie Gilbert  
310 Whittington Pkwy Louisville, KY 40222  
502-429-4430 Ext. 2069 or 800-232-1160 Ext. 2069