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Wisconsin WIC Referral/Communication to CYSHCN Regional Center

- ☐ **Northern CYSHCN Center** fax: 715-261-1901
- ☐ **Northeast CYSHCN Center** fax: 920-969-7975
- ☐ **Southeast CYSHCN Center** fax: 414-266-2225
- ☐ **Southern CYSHCN Center** fax: 608-265-3441
- ☐ **Western CYSHCN Center** fax: 715-726-7910

WIC Staff: _____
WIC Project: _____
Phone: _____
Fax: _____
E-Mail _____

Infant/Child Name: _____ **Date of birth:** _____ **Race:** _____ **Latino?** No
Parent/Guardian Name: _____ **Home or Cell Phone:** _____
Street Address: _____ **Work Phone:** _____
City: _____ **State** WI **Zip** _____ **County** _____ **E-Mail** _____
Diagnosis or special need of child if known: _____
Special need of parent if known (i.e. teen parent, disability, ƭl·ƴƎdzl·ƎŜ l·ăăʎăǘl·ƴŎŜƩ homeless, eǘŎϕύ _____
_____
Primary Health Care Provider: _____
Health Care Coverage:
- ☐ **MA/BadgerCare Plus**
- ☐ **Health insurance from an employer, agent, or insurance company**
- ☐ **Health services: Indian, migrant or student, FQHC**
- ☐ **Other insurance**
- ☐ **No insurance**
- ☐ **Unknown**

Parental concern/reason for referral:

- ☐ **Health benefits**
- ☐ **Connection to Birth to 3 or Early Childhood Education**
- ☐ **Education-related services**
- ☐ **Transportation/meals/lodging for health care**
- ☐ **Health care coordination**
- ☐ **Special foods/formulas beyond what WIC offers**
- ☐ **Parent-to-parent support**
- ☐ **Respite care**
- ☐ **Special equipment** _____
- ☐ **Information:** _____
- ☐ **Other:** _____

Additional concerns of parent or referring RD:

_____
_____
_____
_____
_____
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_____
_____

Regional Center Referral Response:

- ☐ **Family contact achieved and services provided**
- ☐ **Family contact achieved and services declined**
- ☐ **Unable to contact family**
- ☐ **Other comments:** _____

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Signature of Person Legally Authorized to Give Consent for this Child:

_____ DATE _____

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