

CaCoon Program Referral Form

Please fax or scan and send this referral form to the CaCoon Program in the child's county of residence.

CHILD/FAMILY CONTACT INFORMATION	
Child's Name: _____ Date of Birth: / / Parent/Guardian: _____ Relationship to the Child: _____ Home Address: _____ Apt #: _____ City: _____ County: _____ Primary Phone: _____ Other Phone: _____ Primary Language: _____ Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No Type of Insurance: <input type="checkbox"/> Private <input type="checkbox"/> OHP/Medicaid <input type="checkbox"/> Uninsured <input type="checkbox"/> Other: <input type="checkbox"/> Family is aware of the referral	
REASON FOR REFERRAL TO CACOON	
Your concerns are (check all that apply): <input type="checkbox"/> Infant/child has medical condition (describe): _____ <input type="checkbox"/> Infant/child has delayed growth or development <input type="checkbox"/> Screening tool indicates concerns <input type="checkbox"/> Screening tool used: <input type="checkbox"/> Substance abuse/Drug exposed infant <input type="checkbox"/> Teen/Young parent <input type="checkbox"/> Maternal/Infant bonding <input type="checkbox"/> Other concerns: _____	Child/Family is in need of: <input type="checkbox"/> Care coordination <input type="checkbox"/> Medical condition monitoring <input type="checkbox"/> Developmental monitoring <input type="checkbox"/> Parental support or coping assistance related to child <input type="checkbox"/> Assistance with transition to adulthood <input type="checkbox"/> Assistance with housing/food/transportation <input type="checkbox"/> Other: _____
Additional Information:	
Child/family has also been referred to: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Specialty Health Care <input type="checkbox"/> Early Intervention/Early Childhood Special Education <input type="checkbox"/> Mental Health </div> <div> <input type="checkbox"/> Developmental Disabilities <input type="checkbox"/> Early Head Start/Head Start <input type="checkbox"/> Other: _____ </div> </div>	
PROVIDER INFORMATION	
Name and title of provider making referral: _____ Address: _____ Office Phone: _____ Office Fax: _____ Is the referring provider the child's Primary Care Provider (PCP)? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, indicate name of PCP: _____	
Primary contact for receiving feedback about referral: _____ Best time to communicate: _____ Best communication method for feedback: <input type="checkbox"/> Fax: _____ <input type="checkbox"/> Phone: _____	
CaCoon Program: Please complete the section below and return to the referral source above	
FEEDBACK TO REFERRING PROVIDER	
<input type="checkbox"/> Child/Family is getting CaCoon services <input type="checkbox"/> Child/Family is getting Babies First services <input type="checkbox"/> Family was referred to: <input type="checkbox"/> Family declined services <input type="checkbox"/> Contacted family – No response (Date:)	Contact Information Public Health Nurse: _____ Phone: _____ Fax: _____ Email: _____

Local County CaCoon Program Contact Information

Baker County Phone: 541-523-8211 Fax: 541-523-8242	Harney County Phone: 541-573-2271 Fax: 541-573-8388	Marion County Phone: 503-373-3781 Fax: 503-566-2948
Benton County Phone: 541-766-6835 Fax: 541-766-6186	Hood River County Phone: 541-386-1115 Fax: 541-386-9181	Morrow County Phone: 541-676-5421 Fax: 541-676-5652
Clackamas County Phone: 503-742-5382 Fax: 503-655-8350	Jackson County Phone: 541-770-7707 Fax: 541-774-7977	Multnomah County Phone: 503-988-3520 Fax: 503-988-6501
Clatsop County Phone: 503-325-8500 Fax: 503-325-8678	Jefferson County Phone: 541-475-4456 Fax: 541-475-0132	Polk County Phone: 503-623-8175 Fax: 503-831-3499
Columbia County Phone: 503-397-4651 Fax: 503-397-1424	Josephine County Phone: 541-474-5335 Fax: 541-474-5353	Tillamook County Phone: 503-842-3900 Fax: 503-842-3983
Coos County Phone: 541-756-2020 Fax: 541-756-5828	Klamath County Phone: 541-882-8846 Fax: 541-885-3638	Umatilla County Phone: 541-278-5432 Fax: 541-278-5433
Crook County Phone: 541-447-5165 Fax: 541-447-3093	Lake County Phone: 541-947-6045 Fax: 541-947-4563	Union County Phone: 541-962-8801 Fax: 541-963-0520
Curry County Phone: 541-247-3300 Fax: 541-247-5601	Lane County Phone: 541-682-4013 Fax: 541-682-2455	Wasco/Sherman/Gilliam Phone: 541-506-2617 Fax: 541-506-2601
Deschutes County Phone: 541-322-7423 Fax: 541-322-7465	Lincoln County Phone: 541-265-0412 Fax: 541-265-4113	Washington County Phone: 503-846-8881 Fax: 503-846-4522
Douglas County Phone: 541-440-3500 Fax: 541-957-3704	Linn County Phone: 541-967-3888 Fax: 541-926-8903	Wheeler County Phone: 541-763-2725 Fax: 541-763-2850
Grant County Phone: 541-575-0429 Fax: 541-575-3604	Malheur County Phone: 541-889-7279 Fax: 541-889-8468	Yamhill County Phone: 503-434-7443 Fax: 503-472-9731

For general information, contact:

Oregon Center for Children and Youth with Special Health Needs

707 SW Gaines St.
Portland, OR 97239
www.occyshn.org

Toll Free: 1-877-307-7070
Phone: 503-494-8303