

**HEALTH REFERRAL FORM  
SEQUATCHIE VALLEY HEAD START  
170 Smith Lane, South Pittsburg, TN 37380**

\_\_\_\_\_  
(CENTER LOCATION)

**\*\*Parent/Guardian,**

The purpose of this form is to document health referral follow-up for the Head Start record. Please take this form with you to the health care provider that your child is going to for follow-up evaluation. Give to the health care provider to read, and have the health care provider document the findings and, if applicable, the diagnosis, suggested treatment, and follow-up needed. Return this form to the Head Start center.

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CHILD'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

REFERRED TO: \_\_\_\_\_

REASON FOR REFERRAL: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Signature of person making referral)                      DATE: \_\_\_\_\_  
(Date of referral)

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**\*\*Attention Health Care Provider**

**Please complete this section and return to Head Start**

**Findings:**

**Diagnosis, Suggested Treatment, and Follow-up:**

**Does child need to return to you for more follow-up?**    YES \_\_\_\_\_ NO \_\_\_\_\_  
If yes, when: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Health Care Provider**                      **Date**

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Distribution: When form is returned to center after follow-up appointment: WHITE Copy to HSO  
YELLOW Copy to Child's Center File