

# REFERRAL FORM

- Medically Handicapped Children's Program
- Disabled Children's Program (DCP)
- Genetically Handicapped Persons Program

RETURN FORM TO:  
 DHHS.MHCPReferrals@nebraska.gov

All fields marked with \* are required.  
 Please attach a signed release with referral.

Referral Date\*

**PATIENT INFORMATION**

Patient Name*	Patient Date of Birth*	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Patient SSN*
Parent/Guardian Name*	Phone* <input type="checkbox"/> Home <input type="checkbox"/> Cell	Email	
Address*		City*	Zip*

**MEDICAL DIAGNOSIS**

Medical Diagnosis\*(Enter "DCP" for Disabled Children's Program referral).

Has patient been hospitalized for this problem? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospital	Admission Date	Discharge Date
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Treating Physician Name	Treating Physician Name
Address	Address
City/State/Zip	City/State/Zip
Phone	Phone

**INSURANCE INFORMATION**    Is patient covered by:    Insurance    Medicaid

Insurance Company and Policy Number

Medicaid Plan and Policy Number

Additional Information:

Referral made by*	Comments:
Facility (may use n/a)*	
Address	
Phone*	
Email*	