

**ARIZONA DEPARTMENT OF
HEALTH SERVICES
CHILDREN'S REHABILITATIVE
SERVICES (CRS)**

Please send this form to the clinic nearest you:

124 W. Thomas Rd., Phoenix, AZ 85013 (800) 392-2222 Tel-(602) 406-5731 or Fax-(602) 406-7166
 2600 N. Wyatt Dr., Tucson, AZ 85712 (800) 231-8261 Tel-(520) 324-5437 or Fax-(520) 324-3233
 1200 N. Beaver, Flagstaff, AZ 86001 (800) 232-1018 Tel-(928) 773-2054 or Fax-(928) 773-2286
 2400 Avenue A, Yuma, AZ 85364 (800) 837-7309 Tel-(928) 336-7095 or Fax-(928) 336-7497

CRS APPLICATION FORM

TODAY'S DATE:

CHILD'S NAME (Last, First, Middle)		RACE	SEX M F	DATE OF BIRTH (mo/day/yr) / /	
PARENT OR GUARDIAN (Last Name, First Name)			RELATIONSHIP TO CHILD Natural Parent (s) Adoptive Foster Other		
CHILD'S ADDRESS	STREET	CITY	STATE	ZIP CODE	COUNTY
				US Citizen Yes or No	
HOME TELEPHONE () -	MESSAGE /CELL PHONE NUMBER () -	WORK PHONE NUMBER () -	E-MAIL ADDRESS		
IN EMERGENCY NOTIFY (Name, Relationship, Address, Telephone)					
CHILD'S Primary Care Practitioner		ADDRESS		PHONE NUMBER	
REFERRED BY: (Name, address, phone) (This individual verifies that the child's parent/guardian has been notified about this referral.)					
REASON FOR REFERRAL TO CRS:					
LIST PRIMARY DIAGNOSES (e.g., Cleft Lip, VSD, Cerebral Palsy, etc.) IF AVAILABLE, <u>PLEASE SEND RECORDS WITH THIS FORM.</u>					
1)		4)			
2)		5)			
3)		6)			
LIST ANY KNOWN ALLERGIES					
1)	2)	3)	4)		
HAS CHILD RECEIVED CRS SERVICES BEFORE?:		YEAR?	WHERE?	PRIMARY LANGUAGE?	
YES NO					
NAME OF PERSON WHO COMPLETED THIS FORM		ADDRESS	PHONE () --	RELATIONSHIP TO PATIENT	

PERMISSION TO OBTAIN RECORDS

I hereby authorize and request the CHILDREN'S REHABILITATIVE SERVICES through the authorized contractors, to request and obtain photocopies of medical records concerning the above named patient:

Obtain records from:

Primary Care Practitioner _____ Address: _____

Specialist: _____ Address: _____

Specialist: _____ Address: _____

Therapist/Education: _____ Address: _____

This consent will expire one year after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify the Children's Rehabilitative Services clinic in writing to that effect. I understand that a photocopy or facsimile of this authorization is considered acceptable in lieu of the original.

Signature of Consenting Party

Date

Relationship to Patient

AHCCCS PLAN [] YES [] NO HEALTH INSURANCE [] YES [] NO *Please include copy of insurance information or card.*

FOR CRS CLINIC USE ONLY

APPLICATION REVIEWED BY:		DATE	Approved	
SPECIALTY CLINIC ASSIGNMENTS:				
PEND- diagnostic tests	PEND- waiting for medical documentation	DENY- no medical documentation	DENY-not medically eligible	DENY . Other reason