CHRISTIAN COMMUNITY HEALTH CENTER

REFERRAL FORM

Referral Date: _____ **Date of Birth:** _____ / _____ / _____

Client/Patient Name: _____ **Address:** _____

Parent/Guardian Name (if applicable): _____ **Email:** _____

Primary Phone: (___)_____ **Secondary Phone:** (___) _____

Insurance Type: ☐**Uninsured/self-pay** ☐**Medicaid** ☐**Private insurance** _____

☐**Medicare** ☐**HMO or PPO** ☐ **MCO** ☐**Other** _____

Type of Referral:

__Medical: specify_____	__DUI/Alcohol/Drug Abuse	__Spiritual Support
__Case management	__Mental Health	__Food Services
__Housing	__Peer Services/Support	__Legal
__Employment/Vocational Services	__Support Groups	__Emergency Assistance
__GED/Educational Services	__Transportation	__Homeless/Shelter services
__Psychiatry	__Sickle cell	__Domestic Violence services
__Ryan White	__Wellness/Health Education	__Ophthalmology
__Opioid MAT Program	__Nutrition	__Other_____
__ Dental/Oral health: (please attach oral health assessment)	__Care coordination/management	

Referral Agency/CCHC program: _____ **Address:** _____

Contact Name: _____ **Phone Number:** (____)_____

Reason for Referral/Presenting Problem/Patient or Client Goal/Notes: _____

_____

_____

Referred By: Evelyn Davis **Title:** Prevention

Program: Footprints **Phone:** (773) 233-8524 x 3216

Staff Signature: _____ **Fax:** (773) 233-5853

**Attach any required client/patient documentation to referral form (Obtain signed Authorization for Release of Protected Health Information form from patient/client, as applicable); All applicable federal/state/local HIPAA/confidentiality laws/rules apply.*

**Please place a copy in the client/patient record*

Referral Outcome:

Appointment Date: _____ / _____ / _____ Time: _____: _____ am/pm

Did client make appt? Yes ☐ No ☐ If no, rescheduled date? Yes ☐ No ☐ New Appointment Date/Time: _____

Appointment Comments: _____

Received by: _____ Title: _____ Date: _____

Note: Please return completed form with referral outcome to the referring staff person