Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adams County Services

Referral Form - English

|  |  |  |
| --- | --- | --- |
|  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT/CLIENT INFORMATION** | | | | | | | | |
| Patient/Client Name (being referred): | | | | | | | | |
| Date of Birth/Expected Delivery Date: | | | | | | Sex:  Male  Female | | |
| Parent Name (if applicable):  N/A | | | | | | | | |
| Primary Language | English  Spanish  Other(Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| Address | | | Apt/Unit # | | | | City | Zip |
| Home Phone #: | | Cell Phone #: | | | Email Address: | | | |
| Reason for Referral: | | | | | | | | |
| Screening/Evaluation Tool (if applicable): | | | | Medical Diagnosis (if applicable):  N/A | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **REFERRING AGENCY/PRACTICE INFORMATION** | | | | | | |
| Agency/Practice Name: | | | | | | |
| Address | | | | City | | Zip |
| Phone #: | Fax #: | | Email: | | | |
| Referring Staff Name: | | Title: | | | Phone #: | |

**FOR OFFICE USE ONLY: Date Referral Received: \_\_\_\_\_\_\_\_\_\_\_\_ Date Status Update Sent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_** 03/2014

***OTHER***

• • •

*Agency Name:*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Fax:* \_\_\_**\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_

***TRI-COUNTY HEALTH DEPARTMENT***

• • •

**Program:**

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

*Fax:* ***(303) 452-9712***

***ORAL HEALTH***

• ***(Dental)*** •

**Clinic Name:**

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

*Fax:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***PRIMARY CARE***

• ***(Medical)*** •

**Clinic Name:**

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

*Fax:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **HOME VISITATION PROGRAMS**

• • •

**\_\_\_ Nurse Family Partnership (NFP)**

*Tri-County Health Department*

(Adams, Arapahoe, & Douglas County)

*Fax:* ***(303) 255-6290***

**\_\_\_ Nurse Family Partnership (NFP)**

*St. Anthony’s*

(Adams & Denver County)

*Fax:* ***(303) 269-2970***

**\_\_\_ Parents as Teachers (PAT)**

*Growing Home*

*Fax:* ***(303) 426-0560***

**\_\_\_ Home Instruction for Parents of Preschool Youngsters (HIPPY)**

*In transition – stay tuned*

***Please read the following statements completely and initial next to the ones that you agree with before signing this document***

\_\_\_\_ I have been fully informed and advised of the referral being made

\_\_\_\_ I agree and give my full consent to have the referral made and to share the information above with the program/agency specified in the column to the right

(*Participation in program is voluntary and at any time you may withdrawal)*

\_\_\_\_ I understand that there is NO COST to me for the referral

\_\_\_\_ I give consent for referring agency to obtain status of referral

**Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**