 

 Insight #:

 Reg. Date:

TRI-COUNTY HEALTH DEPARTMENT

HCP REFERRAL FORM

Phone: 303-761-1340 FAX: 303-761-1528

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| Source of Request: **Name:** **Phone:** **Fax:**  | For Tri-County use only Referral Taken by: **Referral Date:** |
| Client Name ( M / F )  | **DOB**  |
| Mother Father Guardian |
| Address | **Phone(s)** |
| County | **Primary Language:****Interpreter needed? Y N** |
| PCP | **Insurance**  |
| **Diagnosis/Condition** |
| **Referral Reason**  |
| **Referral Information** |
| **Parent Notified? Yes No** |
| For Tri-County use only **Date:****Encounter Notes:**  | **Referral Source Follow Up*** **Initial Referral Feedback faxed**
* **Verbal feedback given**
* **Documented in Insight**

**Date Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**For questions about HCP Care Coordination services, please call the number(s) below:**

Referral Intake Coordinator OR HCP Nursing Program Coordinator

(303) 783-7126 (303) 783-7139