 

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 onlyReferral 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