SOCIAL SERVICE REFERRAL FORM

REC#: _____ LAST NAME: _____ FIRST NAME: _____ DOB: ____/____/____

INSURANCE: NO INSURANCE LOVELACE MOLINA PRESBYTERIAN BCBS PRESUMPTIVE

ADDRESS: _____ ZIP CODE: _____

PHONE: _____ CELL: _____ DATE OF REFERRAL: _____/_____/_____

***REASON FOR REFERRAL*: _____**

_____

_____

□ SUBSTANCE ABUSE □ HOME SAFETY □ ORAL HEALTH □ MENTAL HEALTH □ DOMESTIC VIOLENCE

□ TEEN PREGNANCY PREVENTION □ MEDICAL PROVIDER □ TOBACCO CESSATION □ EARLY HEAD START

□ PRENATAL HEALTH EDUCATION □ HOME VISITING PROGRAM □ PART-C PROVIDER: _____

□ OTHER: _____

REFERRED TO:

AGENCY: _____ CONTACT NAME: _____

ADDRESS: _____ PHONE: _____

***REFERRED BY:* _____ DATE: _____**

PHONE: _____

The importance of attending my referral has been explained to me. I understand that LCDF/Social Services will not assume responsibility as a result of my not attending my referral.

CLIENT SIGNATURE: _____ DATE: _____/_____/_____

DATE: _____/_____/_____ FOLLOW-UP OUTCOME: _____

_____

DATE: _____/_____/_____ FOLLOW-UP OUTCOME: _____

_____

*** Signature is required at end of each entry ***

I decline service referral: _____ _____
Patient Signature Date

Referral Status:

☐ Denied Community Resource ☐ No Longer Applicable ☐ Obtained Community Resource
☐ Pending Community Resource ☐ Refused Community Resource ☐ Other (Specify) _____