Shalom Free Clinic Referral Sheet

Phone: (530) 518-8300 Fax: (530) 342-2445

Date: _____

Patient Name: _____ DOB: _____

Address:_____ Phone: _____

Significant Adult Phone Number: _____ Relationship: _____

Referral type: Medical Psychological

Diagnosis (i.e. depression, anxiety disorder, PSTD, etc.):

_____

Medications:

_____

Allergies:

_____

Reason for Referral:

Counseling (group/individual) Medication evaluation

Acute medical problem (please specify): _____

Plans for follow-up:

_____

Professional Contacts (case managers, medical providers, etc.)

Name: _____ Title: _____ Phone: _____

Name: _____ Title: _____ Phone: _____

Name: _____ Title: _____ Phone: _____

Services Requested	For Whom	Relevant Symptoms
Evaluation	Patient	
Treatment	Family	

Previous evaluation information: _____

Referring provider name: _____ Organization: _____

Telephone: _____ FAX: _____ Office contact _____

This form must be printed, signed, and faxed to the clinic by provider.

_____ _____

Provider Date Patient Date

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