NWHHR Referral Form

Today’s Date:      Your Name:

Contact Information:

Referring Agency

 [ ]  HMC [ ]  ICCS [ ]  NWIRP

|  |
| --- |
| Client Information |
| Client Name:       | DOB:       |
| Gender: [ ]  M [ ]  F | Phone:       |
| Address:       |
| Country of Origin:       | Ethnicity:       |
| Language(s) client speaks: |       |
| Is the client a primary or secondary survivor of torture? | [ ]  Yes [ ]  No |
| Client is being referred for: | [ ]  Medical[ ]  Mental Health | [ ]  Legal[ ]  Other:       |
| Please describe more about the issue for which they are being referred: |       |
| Is the client on Medicaid or have another form of insurance? | [ ]  Yes [ ]  No |
| If yes, Provider One # |       |
| Does the client know they are being referred? | [ ]  Yes [ ]  No |
| Is there any other information we should know about this client? |       |

**Follow-Up NWHHR ONLY:**

The client was contacted on

The client was contacted by (name and contact info)

[ ]  The client was unable to be reached

[ ]  The client declined services

[ ]  The client accepted services and an intake is established for (date and time)