NAPA COUNTY HEALTH CARE UNIVERSAL REFERRAL

A Tradition of Stewards
A Commitment to Service

2344 Old Sonoma Rd.
Napa, CA 94559

REFERRED TO: _____ **Date:**_____
Instructions: Referring Agency Fax to Clinic Ole 254-1779, Medication Clinic 299-2165, Alcohol & Drug Services 259-8716

IDENTIFYING INFORMATION:

PERSON BEING REFERRED: _____ DOB: _____ Age:____
LAST NAME FIRST NAME

ADDRESS: _____ GENDER: ☐Male ☐ Female

PHONE: _____PRIMARY LANGUAGE: _____☐Interpreting needed/language:_____
Ok to leave message? __yes __no Physical Limitations_____

Funding Source: __MediCal __CMSP __MediCare __Sliding Scale __Commercial Ins.

CURRENT ENROLLED IN: ☐ PC: _____☐ MH: _____ ☐ ADS: _____

☐ PH program: _____ ☐ NONE: _____☐ UNKNOWN: _____Other_____

INDIVIDUAL INFORMED OF REFERRAL on (date):_____ IF NOT, special circumstances:_____

REASON FOR REFERRAL: _____

CURRENT WORKING DIAGNOSES (If Known): _____

CURRENT MEDS if KNOWN: _____

Allergies_____ Referral Urgency __High __Medium __Low

REFERRING AGENCY/DEPARTMENT:

☐ HHSA: _____ ☐ Primary Care: _____

☐ Emergency Department_____ ☐ Inpatient Facility: _____

☐ Community partners: _____ ☐ Other: _____

REFERRED BY: _____ CONTACT INFO: (fax/phone) _____
(Contact Person-PLEASE PRINT)

BEST TIME/DAYS to CONTACT: _____

AUTHORIZATION TO RELEASE AND EXCHANGE INFORMATION ATTACHED ☐ YES ☐NO
IF NO explain: _____

SUPPORTING DOCUMENTATION (list – see guidelines for recommended supporting documents for referral to different programs) _____

DISPOSITION

☐ Assessment Scheduled: _____
☐ Assessment completed-Recommendations attached: _____
☐ Additional information needed: _____
☐ Alternative referral recommended: _____
☐ Referral declined by beneficiary: _____
☐ Unable to contact referred party: _____
☐ Enrolled in treatment (Date/Service/Contact Person):

Appointment date(s): _____ with Provider/Team: _____ Contact Info: _____

☐Other /Comments:_____

☐Informed Referring Staff/Agency: Name: _____ by (phone/email/FAX): _____Date: _____