San Juan Public Health Referral Form

Client's Name: _____ Date of Referral: _____
Medicaid ID Number:_____ Address_____
Birthdate:_____ _____
Telephone Number:_____ _____

Referral To: [*Service provider's name, address, and telephone number*]

_____
_____
_____

Referred By: [*Service provider's name, address, and telephone number*]

_____
_____
_____

Reason for Referral:_____

_____
_____
_____

Authorization: I, _____ [*Client's Name*], give my permission to _____ [*Service Provider's Name*], to release this information to _____ [*Care Coordination Provider's Name*]. The information is to be used to assist me in monitoring and coordinating my health care and social service needs.

Signature of client/parent or guardian: _____

Date: _____

Service Provider's Reply (summary of findings, diagnosis, recommendations, comments, as appropriate):

Signature: _____ Date: _____

735 S 200 W PO BOX E BLANDING, UT 84511 PHONE: 435-587-3838 FAX: 435-215-1893