Health Care for the Homeless
INFORMATION RESOURCE CENTER
888/429-3300 • Fax 518/439-7612

#13. REFERRAL/REQUEST FOR SERVICES

Authorization - restorative services of community residences (*HOM 12*)
Case management referral (*MON 16*)
Client referral (*MON 15*)
Client referral (*TRA 3*)
Clinical family services referral (*COT 6*)
Consultation/referral (*FAM 4*)
Convalescent care admission/referral (*BAL 31*)
Dental referral (*THU 3*)
In-team referral (*HIP 4*)
Interagency referral (*COT 3*)
Interagency referral (*POR 5*)
Interagency referral - prenatal care (*POR 3*)
Nutrition referral (*THU 2*)
Outreach referral (*FAM 2*)
Pediatric med. clearance - ambulatory/same day surgery program (*MON 2*)
Pregnancy referral flow sheet (*POR 1*)
Referral form (*BAL 40*)
Referral information (*HOM 13*)
Referral/telephone (*BAL 4*)
Request birth certificate/ID card (*HPH 10*)
Request for change of formula (*MON 3*)
Request for immunization (*MON 4*)
Request for services (*BIR 12*)
Social work referral (*TER 9*)

HOM 12

AUTHORIZATION FOR RESTORATIVE SERVICES OF COMMUNITY RESIDENCES

☐ Initial Authorization

☐ Semi-Annual Authorization

☐ Annual Authorization

CLIENT'S NAME: _____

CLIENT'S MEDICAID NUMBER: _____

ICD.9 DIAGNOSIS: _____

I, the undersigned licensed physician, based on my review of the assessments made available to me, have determined that _____ would benefit from the
(client's name)
provision of mental health restorative services defined pursuant to Part 593 of 14 NYCRR. This determination is in effect for the period _____ to _____, at which time there will be an evaluation for continued stay.

____/____/____ _____ _____
Mo. Day Yr. Name (Please Print) Licensure #

_____
Signature

☐ **Check here if client is enrolled in Managed Care (e.g., an HMO or Managed Care Coordinator Program) and enter primary care physician name and managed care provider identification number.**

_____ _____
Physician **Managed Care Provider ID #**

MON 16

NYCHP - CASE MANAGEMENT REFERRAL FORM

DATE:_____

PATIENT'S NAME:_____ **MR#**_____

SITE:_____ **DOB:**_____

ADDRESS:_____**Rm#**_____ **EMERGENCY CONTACT NAME:**_____

PHONE: (___)_____ **PHONE#:**_____

MOTHER'S NAME:_____ **P.A.#**_____, **IM#**_____

MEDICAID #_____ **SS#**_____-_____-_____

Reason for Referral* (Check all that apply)

_____ Public Assistance Problems

_____ SSI

_____Medicaid

_____WIC

_____Food Pantry

_____Mental Health Clinic Referral (Child or Parent)

_____Crisis Intervention Specify_____

_____ACS Follow-up

_____Food Stamps

_____Other(Immigration, S.A. Prevention, Legal Aide, Housing Problems)

*** Please give details on the above problem(s)**

_____
Provider

Recommedations & Follow up

_____
Case Manager

MON 15

Site: _____

Address: _____

Room #: _____

Phone: _____

Patient Name:

MR #:

DOB:

Mother's Name:

Medicaid #:

NYCHP – REFERRAL FORM

Date: _____

Institution: _____

Clinic: _____

App't. Date: _____

Reason for referral:

Age:

Sex:

Referring Provider: _____

Findings:

Recommendations:

Return to: Date: _____ Consultant: _____

NEW YORK CHILDREN'S HEALTH PROJECT

A PROGRAM OF MONTEFIORE MEDICAL CENTER – ALBERT EINSTEIN COLLEGE OF MEDICINE

317 EAST 64th STREET • NEW YORK, N.Y. 10021

Phone: (212) 535-9779 • Fax: (212) 535-7699

& S, INC (8/95)

Referral Form

TRA 3

HEALTH CARE FOR THE HOMELESS PROGRAM

Referred To:

___ Haight-Ashbury Free Medical Clinic
558 Clayton St. (at Haight St.)
431-1714

___ Lyon-Martin Women's Health Services
1748 Market St., #201 (at Valencia St.)
565-7667

___ Mission Neighborhood Health Center
240 Shotwell St. (at 16th St./So. Van Ness)
552-3870

___ Native American Health Center
56 Julian Ave. (at 14th St./Valencia St.)
621-8051

___ North East Medical Services
1520 Stockton St. (at Columbus St.)
391-9686

___ North of Market Senior Services
333 Turk St. (at Leavenworth St.)
885-2274

___ St. Anthony's Clinic
105 Golden Gate Ave. (at Jones St.)
241-8320

___ South of Market Health Center
551 Minna St. (at 6th St./Mission St.)
626-2951

___ Women's Needs Center
1825 Haight St. (at Shrader St.)
221-7371

___ Tom Waddell Clinic
50 Ivy St. (at Grove St./Polk St.)
554-2950

___ Southeast Health Center
2401 Keith St. (at 3rd St.)
822-2850

___ Potrero Hill Health Center
1050 Wisconsin St. (at Coral St.)
648-3022

___ City Clinic
356 - 7th St. (at Folsom St.)
864-8100

___ Larkin St. Youth Medical Clinic
1050 Larkin St. (at Sutter St.)
673-0911

___ District Health Center # ____

___ San Francisco General Hospital
1001 Potrero Ave. (at 22nd St.)
206-8200
Dept.: _____

___ Other: _____

Person Referred:

Name: _____

Date of Birth: ____/____/____ Gender: ____ F ____ M

Race/ethnicity:

____ African American/Black
____ Hispanic/Latino
____ Caucasian
____ Asian/Pacific Islander
____ Native American/Alaskan
____ Unknown
____ Other _____

Family Status:

____ Unattached to a Group or Family
____ Living in a Family Unit (and) ____ Head of Household
____ Unknown
____ Other _____

Housing Status:

____ Shelter
____ Doubling Up
____ Unknown
____ Other _____
____ Transitional
____ Street/Vehicle/Makeshift

Financial Resources:

____ AFDC
____ WIC
____ VA Benefits
____ Unemployment Insurance
____ None
____ Other _____
____ SSI
____ Food Stamps
____ General Assistance
____ Wages/Pension

Medical Resources:

____ Medi-Cal/medicaid
____ Private Insurance
____ VA Medical
____ Unknown
____ Other _____
____ Medicare
____ Self Pay
____ None

Presenting Problem/Reason for Referral:

_____

_____

_____

_____

_____

• Requested Disposition (Check all that apply):

____ Please assume management of this problem
___ send me periodic status reports
___ call me if plan procedure/admission
____ Refer patient back for follow-up
____ Send me your consultation report
___ advise as to diagnosis
___ suggest medication/treatment
____ Call me when you have seen patient

____ Appointment Date: ____ / ____ / ____ At ____ ____ __m
____ Please schedule appointment for patient
____ Please see as drop-in patient

Signature: _____

Print-Name: _____

Clinic/Agency: _____

Telephone: _____

I hereby consent to release of the above information to the designated provider.

_____ ____/____/____
Signature of Client Dated

_____ ____/____/____
Witness (if Signed by mark "X") Dated

COT 6

Charter Oak Terrace-
Rice Heights
Health Center, Inc.
81 Overlook Terrace, Hartford, CT 06106 • (203) 236-0857

CLINICAL FAMILY SERVICES REFERRAL

Patient: _____ Date: _____

Date of Birth: _____ Time: _____

Address: _____ Referral Source: _____

_____ Phone: _____

Phone: _____ Parents: _____

School: _____ Grade: _____

Legal Guardian: _____ Day Time Phone: _____

Employer: _____ Position: _____

Ethnicity: _____ Language: _____

Why is the person seeking services at this time? _____

_____

Has the person seeking services ever had any thoughts of hurting him/herself (e.g., thoughts of suicide) or actually attempted to hurt him/herself (e.g., attempted suicide)?

_____

_____

Has the person seeking services ever been under the treatment of a mental health professional? If yes, whom? Has he/she ever been hospitalized for psychiatric problems? If so, what hospitals or institutions has the person been in?

_____

_____

Check any that apply to patient:

Behaviors:		Symptoms:	Problems:	
Aggressive	Destructive	Depression	Tics	Sexual Abuse
Overactive	Inattentive	Anxiety	Learning	Neglect
Impulsive	Oppositional	Fears	Speech	Substance Abuse
Unmanageable	Compulsive	Nightmares	Separation	Domestic Violence
Head Banging	Stealing	Psychoses	Physical/Health	Death/Loss
Running Away	Fire Setting	Sleeplessness	Physical Abuse	Soiling/Enuresis
		Loss of Appetite	Homelessness	

How frequently does the person use alcohol or drugs? Has he/she ever been in substance abuse treatment?

_____

_____

Intake Appointment: _____

FAM 4

FHF

CONSULTATION / REFERRAL FORM

Rev. 5/94

Patient Name / D.O.B. / /	Type of Referral ❑ Elective ❑ Urgent ❑ Emergency
MediCal #	Referral Request ❑ Inter Clinic ❑ Out-of-clinic ❑ In-Patient Must check one of the following:
Patient Address ( )	❑ ER ❑ Ancil. service ❑ F U visit X_____ ❑ Surgery ❑ Consultation ❑ Therapy (PT,OT,ST,Psyche) X ___ For ___
City Zip Telephone #	❑ Consult/Treatment ❑ Transportation

Clinical Information **Working Diagnosis:**_____

Referring Provider	REFERRED TO: CONSULTANT/ FACILITY: Name Provider/Facility Telephone Number
Signature Date	Address City Zip

Summary of Findings of Consultant (Please print/ type/ or attach typed summary):

ATTN : Please foreward consultation report to the above address, including " ATTN : Nursing"

White copy: Consultant / Facility Yellow Copy: Referring Clinic UR007

HEALTH CARE FOR THE HOMELESS, INC.

CONVALESCENT CARE ADMISSION/REFERRAL

BAL 31-

Date of Referral:

Primary Diagnosis: Category: Details:

Referring Agency: Agency Contact:

Reason for Referral: Accepted? ☐ Yes ☐ No Reason:

Comments:

Primary Care Provider: Provider Phone #:

CURRENT CLIENT BENEFITS

☐ Pharmacy Assistance ☐ PCMI ☐ Medical Assistance ☐ Unknown

☐ Medicare ☐ VA ☐ None ☐ Comments: _____

SECONDARY DIAGNOSIS

CATEGORY						
General	☐ AIDS	☐ HIV	☐ Anemia	☐ Cancer	☐ Surgery	☐ Tobacco Use
Cardiovascular	☐ CAD	☐ HTN	☐ CHF	☐ DVT	☐ Other	☐
Endocrine	☐ DM/1	☐ DM/2	☐ Thyroid	☐ Gout	☐ Other	☐
Neurologic	☐ Seizures	☐ Stroke	☐ Headache	☐ Other	☐	☐
Gastrointestinal	☐ Gastritis	☐ GERD	☐ Hepatitis B	☐ Hepatitis C	☐ Pancreatitis	☐ Peptic Ulcer
Musculoskeletal	☐ Arthritis	☐ Back Pain	☐ Sprain/Strain	☐ DJD	☐ Fracture	☐ Other
Psychiatric	☐ Depression	☐ Bipolar	☐ Schizophrenia	☐ Other	☐	☐
Respiratory	☐ Asthma	☐ Bronchitis	☐ Emphysema	☐ Pneumonia	☐ URI	☐ Other
Genitourinary	☐ Renal Failure	☐ Prostate	☐ Kidney Infection	☐ Dialysis	☐ Other	☐
Dermatologic	☐ Skin Disorder	☐ Wounds	☐ Burns	☐ Cellulitis	☐ Other	☐
EENT	☐ Thrush	☐ Dental	☐ Eye Problem	☐ Other	☐	☐
Miscellaneous	☐	☐	☐	☐	☐	☐

☐ IVDU ☐ NIVDU ☐ ETOH Last Use: Comments:

☐ Allergies:

Women: LMP_____ ☐ Regular ☐ Irregular Para:

☐ Meds:

Comments:

Treatment Plan:

Emergency Contact:

Date of Birth: SS#: Sex: Race:

CLIENT LAST NAME: FIRST: HCH#:

Physical Examination

ROS

NEURO:

CV:

Resp.:

GI:

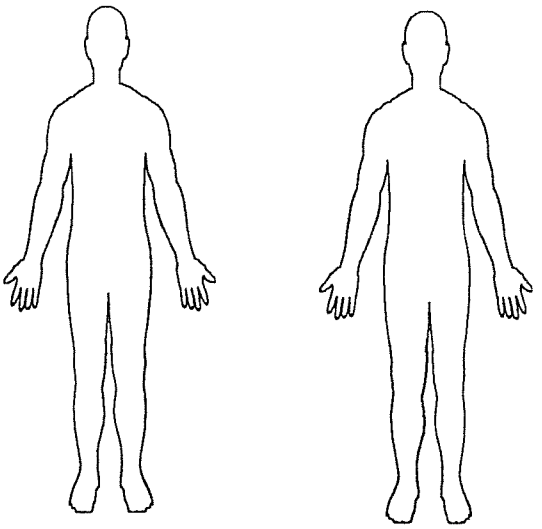
GU:

EENT:

Skin:

Indicate Location and Shape of Skin Abnormalities of Figure Below:

Front *Back*



Notes:

THU 3

THUNDERMIST HEALTH ASSOCIATES, INC.
383 ARNOLD STREET
WOONSOCKET, RI 02895

H.C.H. DENTAL REFERRAL FORM

REFERRAL DATE: _____

PATIENT NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

****

MEDICAL RECORD #: _____

REASON FOR REFERRAL: _____

_____

_____

_____

_____

****

FOR DENTIST/HYGIENIST USE ONLY:

DENTAL CARE PLAN: _____

_____

_____

_____

_____

_____

NEXT VISIT: _____

****

COMMENTS: _____

_____

_____

4/97
clv

HIP 4

HOMELESS INITIATIVE PROGRAM IN-TEAM REFERRAL

TO: _____

REFERRAL OF _____
Client Name

_____/_____/_____
Date Referral Initiated

_____/_____/_____
Date of Birth

_____--_____--_____
Social Security Number

☐ Medical Care

☐ Case Management

☐ Choices for Change

☐ Prenatal Care Coordination

☐ Mntl Hlth/Sub Abuse Assessment

REFERRAL Initiated by: _____ (HIP Team Member Name)

For **Choices** referrals, please indicate where client is staying _____ and ages of children needing care during assessment ____ ____ ____ ____ ____.

____ Asked Client to arrange to see you at:

_____ _____ _____
Shelter/other service site | Day | Time (if applicable)

____ Called to set appointment for client

_____ _____ _____
Appointment set for: Place | Date | Time

Additional Information: _____

Response: ___ Client made appt. ____Client kept appt. ____ No appt./No Show

DATE: _____/_____/_____ Signed: _____

ROUTING: WHITE: Send to Medical Records immediately after referral made. They log it in a tracking book. **CANARY & PINK**: give both to the person receiving the referral. That person will complete the bottom portion within 30 days, marking it "No appt/No Show" if the client did not follow up.
THEN: CANARY (completed with notes and signature) goes to Medical Records to get tracked and filed. PINK goes to the person who initiated the referral. Medical Records will provide ticklers once a month so people initiating referrals can follow up as needed.
HIP Referral Report 3/97

7021871 CH-6864 (MAR 97)

COT 3

INTER-AGENCY REFERRAL FORM

HOMELESS HEALTH CARE

Charter Oak Terra
Rice Heights
Health Center, Inc

TO: _____

_____

DATE: _____ SHELTER SITE: _____

PATIENT'S NAME: _____ D.O.B. _____
(last) (first) (m.i.)

INSURANCE: _____ SEX: _____ RACE: _____

REASON FOR REFERRAL: Consultation Diagnostic Work-up Laboratory/radiology
Other (specify): _____

CHIEF COMPLAINT:

PMH:

CURRENT MEDS:

ALLERGIES:

OTHER INFORMATION:

Signed: _____

Print: _____

To facilitate follow-up in our clinic, please include the following in the consultant's report:

Seen by:

Date:

Diagnosis:

Diagnostic Tests Performed:

Follow-up Appointment:

Findings:

Treatment Plan:

_____
Provider Signature

I hereby give permission to

Please return to:
Homeless Health Care

_____ RN

_____
Provider Agency
for the release of medical
information to

Charter Oak Terrace/Rice Heights
Health Center, Inc.
81 Overlook Terrace
Hartford, CT 06106
Telephone: 236-0857

_____
Referral Agency

_____ _____
Signed Date

POR 5

Meredith L. Tipton
Director Public Health Division

Nadeen M. Daniels
Assistant City Manager
Director, Health & Human Services

CITY OF PORTLAND

Interagency Referral
Health Care for the Homeless
15 Portland Street, Portland, Maine 04101
(207) 874-8445

Date: _____

Client: _____ DOB _____

Referred to _____ From _____

Medicaid Number _____ SSN _____

Reason for Referral: [ ]Evaluation [ ]lab [ ]eye glasses
[ ]X-ray [ ]EKG [ ]counseling
[ ]Other (specify)

_____

Client's chief complaint/symptomatology/diagnosis:

Significant prior medical history:

Current Medications:

ALLERGIES:

Please send any test results to attention of _____
at the above address.
****

Consultant's Report Requested [ ]yes [ ]no
(If yes, please detach and return via client)

Diagnosis/Findings:

Treatment Plan:

Clinician: _____

POR 3

CITY OF PORTLAND
Interagency Referral Prenatal Care
Health Care for the Homeless
15 Portland Street, Portland, Maine 04101
Phone (207) 874-8445 FAX 874-8975

Referred to:
Address:
Phone:
Appt. details:

Client: _____ Telephone: _____

Address: _____

DOB: _____SSN: _____ Medicaid: _____

Reason for Referral:

Pregnancy Information:

G____P____AB____ LMP_____ EDC_____

Pregnancy Testing:

Concerns/Complications:

Public Health/Maternal Child Health Nurse:

Significant prior medical history:

Allergies

Social issues:

Mental Health/Substance Abuse:

Comments:

Date of Referral: _____ Referred by: _____

Homeless Health Provider/Case Manager: _____
Phone: _____ Beeper: _____

THU 2

THUNDERMIST HEALTH ASSOCIATES, INC.
383 ARNOLD STREET
WOONSOCKET, RI 02895

H.C.H. NUTRITION REFERRAL FORM

REFERRAL DATE: _____

PATIENT NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

****
MEDICAL RECORD #: _____

REASON FOR REFERRAL: _____

_____

_____

_____

_____
****
FOR NUTRITIONIST USE ONLY:

NUTRITION PLAN: _____

_____

_____

_____

_____

_____

NEXT VISIT: _____
****
COMMENTS: _____

_____

_____

4/97
clv

FAM 2

❒ URGENT	❒ GENERAL FOLLOW UP	❒ NO FOLLOW UP REQUIRED(I&R)

FHF OUTREACH REFERRAL FORM

P.O. BOX 1240
ALVISO, CA 95002
(408) 262-7944, Ext. 207

Name of person referring/ Site

Last Name of Client | First Name | M.I. | Date

Address | Medi-Cal #/SSN # | FHF Registration Number

City/State | Zip Code | Sex | Date of Birth | Age

Telephone Number | Ethnicity | Language(s) spoken

Comments:

Type of Referral:
❒ Medical ❒ STD Testing ❒ Optometric
❒ Dental ❒ Substance Abuse ❒ Prenatal Care
❒ HIV ❒ Counseling ❒ HIV/AIDS Support Services
❒ Health Ed. (specify) (i.e. hypertension, diabetes, asthma, etc.)

Referral Site/Organization

FHF SERVICES
- ❒ Alviso Health Center
- ❒ CompreCare Health Center
- ❒ St. James Health Center
- ❒ Health Care for the Homeless
- ❒ Proyecto Primavera
- ❒ Blossoms Program
- ❒ WIC
- ❒ Family Planning
- ❒ Comprehensive Perinatal Services Program
- ❒ Childhood Health & Disability Prevention Program(CHDP)
- ❒ Yerba Buena High School Clinic

OUTSIDE LINKAGES
- ❒ East Valley Community Clinic
- ❒ AIDS Legal Services
- ❒ Valley Medical Center
- ❒ County AIDS Program
- ❒ Women's Community Clinic
- ❒ Center For Living W/Dying
- ❒ ARIS of Santa Clara County
- ❒ Mayfield Community Clinic
- ❒ Needle Exchange Program
- ❒ AIDS Benefits Counselors
- ❒ Filipino Task Force on AIDS
- ❒ El Pueblo (San Jose Medical Ctr.)
- ❒ Center for Employment Training
- ❒ Narvaez Hispanic AIDS Program
- ❒ Economic & Social Opportunities
- ❒ Asian Americans for Community Involvement
- ❒ American Red Cross
- ❒ Gardner Health Center
- ❒ Indian Health Center
- ❒ Shelter Hotline
- ❒ Shared Housing
- ❒ Planned Parenthood
- ❒ Bill Wilson Center
- ❒ American Center Society
- ❒ Necessities,& More
- ❒ Bascom Mental Health
- ❒ Bureau of Alcohol and Drug Program (BADP)
- ❒ Gang Intervention Unit
- ❒ Educational Options
- ❒ Chaboya Clinic
- ❒ Tatoo Removal Program

Referral To:

contact person | contact person

organization | organization

address | address

telephone number | telephone numer

MON 2

MONTEFIORE MEDICAL CENTER - AMBULATORY - SAME DAY SURGERY PROGRAM
PEDIATRIC MEDICAL CLEARANCE

Primary Care Provider_____

Name of Procedure_____

Surgeon/Department_____

Patient's Name_____

MR# 900 -_____ **D.O.B.**_____

History: (-) If negative (✓) If abnormal/positive, explain below

Allergies_____ Heart Murmur_____ Recent Exposure to Varicella_____
Asthma_____ Heart Disease_____ Seizure Disorder_____
Pulmonary_____ Other Conditions_____ Sickle Cell Anemia or Variant_____
Bleeding Tendency_____ Previous Surgery_____ Other Hematologic Abnormalities_____
Diabetes_____ Previous Surgical Complications_____ Recent ASA_____
Family History of Bleeding, Muscle Disease or Anesthesia Complications_____

Immunizations up to date? Yes_____ No_____
Chronic (daily) medications? Yes_____ No_____ List Dose & Schedule_____

PHYSICAL EXAM: Temp._____ Pulse_____ Resp. Rate_____ BP_____ Hgt._____ Wgt._____

(-) If negative/normal (✓) If abnormal, explain below

Mental Status_____ Nose_____ Chest_____ Extremities_____
Skin_____ Throat_____ Heart_____ Back_____
Eyes_____ Dentition_____ Lungs_____ Genitalia_____
Ears_____ Neck_____ Abdomen_____ Neurological_____

LAB DATA : Hct_____ Hgb_____ Urinalysis_____ Other_____

SUMMARY OF FINDINGS:_____

SPECIFIC ORDERS PRIOR TO SURGERY: R.N. SIGNATURE

_____/_____
_____/_____
_____/_____

I have discussed the procedure with parent(s). Patient may undergo surgery.

_____ M. D. _____ M. D. Date_____
Print Name Signature

POR1-1

PREGNANCY REFERRAL FLOWSHEET

Homeless Health Program City of Portland Public Health Division

Client: _____ Race: _____ D.O.B. : _____

Address: _____ Telephone: _____

Pregnancy Testing: _____ Date of LMP: _____ Est EDC: _____

Client wishes to continue with pregnancy ☐ Yes ☐ No If "no", provide options counseling and describe here:

For clients planning to continue with pregnancy: **Initials & Date**

Explain sources of affordable prenatal care in the community (examples: Family Practice Unit, 871-6809 Ann McDonough, or 874-2466 Mary McDonough Maine Medical Center OB/Gyn Clinic 871-4227, Mercy Hospital Midwifery Clinic, 879-3000, Mercy Hospital Prenatal 879-3556. _____ _____

Call selected provider: _____ and set up first appointment. _____
Appointment time: _____ Date: _____ To See: _____ _____

☐ Fax an Interagency Referral form to the prenatal provider.

Request that client sign a Release of Information allowing for exchange of information between Public Health and the prenatal provider. _____ _____
☐ Fax or mail the Release of Information to the prenatal provider.

Weeks gestational age at onset of prenatal care. This is either the client's first visit to Homeless Clinic or at a prenatal primary care provider (whichever is first) _____weeks _____ _____

Assess for behaviors (drug use, smoking, etc) and health status (HIV, homelessness) which are immediately threatening to successful pregnancy outcome and counsel accordingly. _____ _____

Offer HIV testing. _____ _____

Provide the client with a copy of the positive pregnancy test &/or a note stating the client is pregnant. (Necessary for WIC enrollment). _____ _____

Refer client to WIC. (874-1156. Address is 510 Cumberland Avenue) _____ _____

WIC Details: _____

Explain Maternal Child Health home visiting program available through Portland Public Health and with client's consent, make MCH referral. _____ _____
(By phone 874-8499 or by placing written Prenatal Referral form in B. Weed's mailbox)

Provide client with sufficient prenatal vitamins to last until first prenatal visit. _____
# of vitamins dispensed _____ Type: _____ _____

POR 1-2

PRENATAL FLOW SHEET Page 2

Enter ICD 9 Code for pregnancy, V22.2 on encounter sheet. _____

Client encouraged to return to Homeless Health Program for support, check-in or other care. _____
Details: _____ _____

Initials: _____ Signature: _____ Initials: _____ Signature: _____

PREGNANCY OUTCOMES DATA
Homeless Health Program, City of Portland Public Health Division

OUTCOME CRITERIA						
Client's Age	< 15	15-19	20-24	25-44	45+	
Race	Asian	Black	AmInd	White	Hisp	Unreported/ Unknown
Infant Birthweight	1500gm or less	1501-2500	>2500 gm	Gest Age _____wks		
Delivery	Date: _____	Vag	C-sect			
HIV Status Known	Pos	Neg	Unknown			
Enrolled in WIC Prenatally	Yes	No	Unknown			
Mother Postpartum WIC	Yes	No	Unknown			
Infant on WIC	Yes	No	Unknown			
Newborn Visit by 4 wks	Yes	No	Unknown			
Postpartum Visit by 8 wks	Yes	No	Unknown			
Maternal Complications	Yes	No	Unknown			
Newborn Complications	Yes	No	Unknown			

bmw 7/97

BAL 40

Health Care for the Homeless, Inc.

111 Park Avenue • Baltimore, MD 21201 • (410)837-5533

Referral Form

Date: _____

SS # _____

Client Last Name: _____ First Name: _____ HCH #: | | | | | |

Date of Birth: ____/____/____ Sex: _____ Insurance: _____ #: _____

REFERRED TO: Name: _____ Mercy Medical? ☐ Yes ☐ No

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____

Date of Appointment: ____/____/____ Time of Appointment: _____ Number of Visits: _____

TYPE OF REFERRAL: (circle one)

				OTHER: (circle one)
1. Dental	13. Radiology	20. ENT	26. Psych ER	18. Clothing
2. Optometry	14. Cardiology	21. Surgery	27. GYN	5. Shelter
3. Ophthalmology	15. GI	22. OT/PT	28. Pain Clinic	7. Food
4. Podiatry	16. Vascular Surgery	23. Neurology	29. Pulmonary	11. Pharmacy
6. Emergency Dept.	17. Orthopedics	24. Neurosurgery	30. PAP Smear	32. Vision Van
9. Substance Abuse	19. Dermatology	25. Urology	31. Mammogram	12. Other: _____

REASON FOR REFERRAL (Presenting Problem(s), Condition(s):

_____ *Signature of Referring Person/Title*

_____ *Date*

_____ *HCH Code*

DISPOSITION:

_____ *Signature and Title*

_____ *Date*

HOM 13-1

HOMES, INC. COMMUNITY LIVING SERVICES - REFERRAL INFORMATION

Date: _____
Referral Source: _____ Contact Person: _____

CLIENT NAME: _____
COUNTY: _____
SEX: _____ AGE: _____
BIRTHDATE: _____
EDUCATION: _____
MARITAL STATUS: _____
IN EMERGENCY NOTIFY: _____
ADDRESS: _____
_____
RELATIONSHIP: _____
PHONE: _____
ALLERGIES: _____
_____
_____

REFERRED TO ICM ROSTER? [ ] yes [ ] no
LEGAL STATUS: _____
SOCIAL SECURITY #: _____
MEDICAID # (STATE): _____
MEDICARE #: _____

DIAGNOSIS DATE GIVEN: _____
AXIS I:
_____
AXIS II:
_____
AXIS III:
_____

RECURRENT INCOME? [ ] yes [ ] no
SOURCE(S)/AMOUNT: _____
OTHER ELIGIBILITY? SSI PA VA SSD
PENSIONS TRUSTS
APPLICATION STARTED? [ ] yes [ ] no
DATE: _____

CURRENT MEDICATIONS:

NAME	DOSAGE/STRENGTH	FREQUENCY

SERIOUS/PERSISTENT PROBLEMS (check):
___ assaultive, threatening
___ bizarre behavior
___ depressed/mood disorder
___ property destructive
___ suicidal ideas/attempts
___ legal/criminal
___ eating disorders
___ fire setting
___ assault/abuse victim
___ sexual abuser
___ substance abuse
___ interpersonal relations
___ developmentally disabled
___ money management
___ hygiene

PSYCHOSOCIAL STATUS (answer Yes, No or N/A)

____ participates in programs and services
____ complies with medication regimen
____ needs medications supervised/administered
____ family and/or social network is supportive
____ able to cope with stressors
____ work experience
____ able to engage in services agency linkages
____ risk for substance use/abuse
____ able to live independently
____ risk for suicide
____ accepts authority/rules
____ able to structure own time
____ capable of ADL skills

DATES OF PSYCHIATRIC TREATMENT

IN-PATIENT Date admit	Date Dischgd	HOSPITAL	EARLY WARNING SIGNS OF MENTAL DETERIORATI

(continued

RECOMMENDED FOLLOW-UP IN COMMUNITY:

___ day treatment/program
___ case management
___ employment aid
___ alcohol/substance abuse service
___ psychiatrist
___ physician
___ therapist
___ OVR

WHAT ARRANGEMENTS HAVE BEEN MADE

PLEASE ATTACH:

[ ] Consent For Information Form
[ ] OT/RT Assessments
[ ] Psychiatric Assessment
[ ] Social Assessment
[ ] Physical Exam
[ ] Nursing Referral
[ ] Physical Assessment
[ ] Psychological Assessment
[ ] Vocational Assessment

Community Living Arrangements: past/current

Residence/Agency	From (mo/yr)	To (mo/yr)	Contact Person

Community Day Programs past/current (day treatment, social clubs, sheltered workshops, etc)

Agency/Address	From (mo/yr)	To (mo/yr)	Contact Person

Community Psychotherapy: past/current

Date	Therapist/Psychiatrist	City

BAL 4

Health Care for the Homeless, Inc.

111 Park Ave. • Baltimore, MD 21201 • (410)837-5533

Referral/Telephone Form

Date:_____

Time:_____

REFERRAL TO/CALL FROM:

Name:_____

Address:_____

_____

Telephone:_____

TYPE OF REFERRAL: (circle one)

1. Dental
2. Optometric
3. Opthomalogic
4. Podiatry
5. Shelter
6. Emergency Department
7. Food/Clothing
8. Outpatient
9. Substance Abuse
10. Emergency Petition
11. Pharmacy
12. Other: _____

_____

_____

TYPE OF CALL: (circle one)

1. Client
2. Emergency Department
3. Hospital Outpatient Clinic
4. Hospital Inpatient
5. Substance Abuse Treatment
6. Mental Health Program
7. Pharmacy
8. Shelter
9. Other: _____

Date of appointment:____/____/____

Time of appointment:_____

HCH MA Provider Number:_____

Duration of Referral:_____

Client Last Name: _____ First Name: _____ HCH ID # ___/___/___/___/___/___/___

Date of Birth: ____/____/____ Sex: _____ Fee Source: _____ #: _____

HCH MAC Client: (Check one) ☐ Yes ☐ No

REASON FOR REFERRAL/CALL:
(Presenting Problem(s), Condition(s), Possible Diagnosis, Need for Social Services, Mental Health Consult)

I agree that the above information and and any additional information requested by _____ can be released to the provider to whom I am being referred.
(provider receiving referral)

_____	_____	_____	_____	___/___/___
(Signature of Client)	*(Date)*	*(Signature of Referring Person/Title)*	*(Date)*	*HCH Code*

ASSESSMENT/PLAN/DISPOSITION:

MAC Authorization Given (Check one)

☐ Yes ☐ No

Signature/Title: _____ Date Completed: ___/___/___ Phone #: _____

HOMELESS PERSONS HEALTH PROJECT

COUNTY OF SANTA CRUZ
HEALTH SERVICES AGENCY

CHART #_____

ISSUE #_____

CLIENT NAME_____ DATE:_____

Please draw a line through any order(s) which do not pertain to your client.

REQUEST FOR BIRTH CERTIFICATE / CALIFORNIA ID CARD:

S: Request for [ ] Birth Cert (County & State of birth:_____)

[ ] California ID card_____

_____

_____

O:_____

_____

_____

_____

A1:_____

_____

_____

_____

A2 Client completed form HSA-600 (Request for Birth Certificate)_____

Advised client that return Birth Cert/CA ID will likely take at least 6 weeks

Individual (specific) county request letter sent along with request form client

Claim on Treasury (AUD-7) sent to Claims Department along with all other paperwork for approval and processing

Client to F/U with HPHP as needed

_____

SIGNED_____ Page #_____

MON 3

MONTEFIORE

MONTEFIORE MEDICAL CENTER

The University Hospital
for the Albert Einstein
College of Medicine

Irwin Redlener, M.D.
Division Director

Anne Greene, M.D.
Medical Director

Karen B. Redlener
Executive Director

Clinical Staff

Sharon P. Joseph, M.D
Associate Medical Director
Anne Beal, M.D., M.P.H.
Sariya Pacheco, M.D.
Elizabeth Hobson, M.D.
Alan Shapiro, M.D.
Adolescent Health

Karen Coutrier, R.N., P.N.P.

Powers Assessment Center

Maureen Diaz, R.N., P.N.P.
Marcy Johnson, R.N., M.N.
Amy Rowe, R.N., P.N.P.
June Greene, R.N.

Nursing and Outreach Services

Wendy Quinones, R.N.
Coordinator

Hope DeRogatis, R.N.
Lisa Motessi, R.N.
Lillian Satturia, R.N.
Esmine Leonard, R.N.
Cynthia McIver
Rafael Cruz
Angela Chachere
Ysaura Taveras

Mental Health and
Case Management Services

Lourdes Rigual-Lynch, Ph.D.
Coordinator

Grace Padilla-Matthew
Case Manager

Nancy Ross

Nutrition Services

Jose Wendel, MS, RD
Program Director
Health and Nutrition
Action Initiative

Administration

Anne Tallent, M.P.H.
Administrator

Gloria A. Ramsey
Operations Manager

Michael I. Silver
Finance Manager

David Sherrille R. Seraphin
Information Systems &
Technology Manager

Glynis Hunt-Murray
Medical Records
& Billing Manager

Heather L. Gershman

NEW YORK CHILDREN'S HEALTH PROJECT*
DIVISION OF COMMUNITY PEDIATRICS
317 EAST 64TH STREET, NEW YORK, NEW YORK 10021
Phone: (212) 535-9779 / Fax: (212) 535-7699

Date: _____

To: WIC CPA
Re: Request for change of formula

Child's Name: _____

Date of Birth: _____

WIC # (if available): _____

Current Formula: _____

Formula Requested*: _____

Reason for requested change**:
[ ] Rash/Skin problems _____
[ ] Diarrhea _____
[ ] Constipation _____
[ ] Vomiting _____
[ ] Other _____
_____

Expected duration of change: _____

_____
Provider Signature

* WIC requires a trial on Enfamil befor changing to Similac or Prosobee before changing to Isomil. A trial on contract formula (Enfamil or Prosobee) is not required for a change to Nutramigen, Pregestimil, Alimentum, Lactofree or other 'specialized' formula.
** In general, only medical reasons are appropriate to request a formula change.

Notes:
1. If uncertain whether WIC can accommodate a specific request, please check with the WIC office or with the NYCHP case manager or nutritionist.
2. WIC will also accommodate verbal (phone) orders from a Medical Provider.

September 1996
C:\OFFICE\WPWIN\WPDOCS\ENTITLEM\WICFOCH.WPD

MON 4

Montefiore Medical Center
Albert Einstein College of Medicine
Division of Community Pediatrics

		Yes	No	Don't Know
1.	Does the child have allergies to medications, eggs, or any previous vaccines?	☐	☐	☐
2.	Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
3.	Has the child had a seizure or a changing neurological disorder?	☐	☐	☐
4.	Does the child have cancer, an immune system disorder, or does the child take medications that suppress the immune system such as steroids (by mouth or injection) or anti-cancer drugs?	☐	☐	☐
5.	Does someone with whom the child lives (or has close contact) have cancer, an immune system disorder, or take medications that suppress the immune system such as steroids (by mouth or injection), anti-cancer drugs or chronic asprin therapy?	☐	☐	☐
6.	Has the child received blood, plasma, or gammaglobulin in the past 5 months?	☐	☐	☐
7.	Is the patient pregnant or at risk for becoming pregnant within the next three months or is anyone in the household pregnant who has never had varicella?	☐	☐	☐
8.	Has child had varicella?	☐	☐	☐

IMM.17 REV. (9/93)

NEW YORK CITY DEPARTMENT OF HEALTH
REQUEST FOR IMMUNIZATION

PRINT CLEARLY IN CAPITAL LETTERS (USE A BALLLPOINT PEN)

PERSON TO RECEIVE VACCINE

LAST NAME | FIRST NAME | MIDDLE NAME | SOCIAL SECURITY NUMER

STREET ADDRESS | APT. | BOROUGH/CITY | STATE (Abbreviate) | ZIP CODE

BIRTH DATE (Month / Day / Year) | AGE | SEX ☐ MALE 1 ☐ FEMALE 2 | MEDICAID NUMBER

CLINIC NAME AND ADDRESS

I have been given a copy and have read, or have had explained to me, the information contained in the vaccine information pamphlet or the appropriate important information statement about the disease(s) and vaccine(s) listed below.

VACCINE REQUESTED	AUTHORIZATION				MANUFACTURER			SIGNATURE/TITLE OF INOCULATOR
	DOSE #	PATIENT OR GUARDIAN SIGNATURE & DATE	DATE VIP	DATE OF VACCINE	MFR'S ID	INJECTION SITE	LOT NO.	
DTP (To 6 yrs.)								
DTaP								
Td (7 yrs. up)								
DT (Special)								
POLIO								
MMR								
HIB								
HEP B								
INFLUENZA								
Other (Specify)								

BIR 12

REQUEST FOR SERVICES

TO: BIRMINGHAM HEALTH CARE

RE: CLIENT NAME _____

CLIENT DATE OF BIRTH _____

CLIENT SOCIAL SECURITY NUMBER _____

This is to verify that the above named client is being provided services from

_____

NAME OF SHELTER OR TREATMENT FACILITY

and we are requesting that Birmingham Health Care provide additional supportive services to this client.

Nature of services requested to be provided by Birmingham Health Care:

By _____ Date _____

SIGNATURE OF SOCIAL WORKER / COUNSELOR / CASE MANAGER

TER 9

SOCIAL WORK REFERRAL
FOR HOMELESS BOISE CLINIC
CLIENTS

TODAY'S DATE: _____

CLIENT NAME: _____

D.O.B.: _____ **PHONE:** _____

Reason for referral or services desired:

( ) Help filling Rx.
( ) Counseling
( ) Intake new client
( ) Dental and/or vision
( ) Specialty consults, Rx. attached
( ) SSI
( ) Re-certification
( ) Transportation, housing, food

Additional services through Ada County Community Services

1. Emergency assistance
   - ( ) Bus tickets (medical trips only)
   - ( ) Gas vouchers (medical trips only)
   - ( ) Food
   - ( ) Prescriptions not covered by TRHS
2. Other non-emergency
   - ( ) Rent
   - ( ) Utilities
   - ( ) Burial expenses
3. Medical assistance
   - ( ) Hospitalization ER
   - ( ) Hospitalization non-ER
   - ( ) M.D. consult
   - ( ) Prescriptions for hospital/doctors
   - ( ) Dental extraction
4. Medical placement
   - ( ) Shelter care placement
   - ( ) Nursing home placement
   - ( ) Hotel rooms for respite (medical rehab)
5. Other: _____

Future Social Work Appointment **Time:** _____ **Date:** _____

Health Care Provider
Signature: _____