

New Patient Referral Intake Form

Referring Agency (or Person)

Referring Agency Name:
Referring Agency Contact Name:
Referring Agency Phone:
Referring Agency Email:

Patient Information

Name:
DOB:
Address:
Phone Numbers (two if possible):

Guardian Information

Guardian Name:
Guardian Relation to Patient:
Guardian Address:
Guardian Phone Number:
Permission to Treat

Insurance Status
Is transportation needed (if so, from where)?

Current Living Situation:

General Information/Background about Youth:

Known Medical Needs/Medical History:
**Screen for any emergent needs that should be sent to ED*

For Clinic Staff Use

Inpatient/Outpatient EMR & HIE Records review:

Immunizations: