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)