PATIENT REFERRAL FORM

Referred by:

Date

Event:

Client Information

Reason for Referral

Check one: [ ] Client [ ] Client + Spouse [ ] Client + Children [ ] Family [ ] Child

Check one: [ ] Primary Care [ ] Family Planning [ ] Dental [ ] Vision
[ ] Enrollment into Health Insurance

Check one: Is client a resident of Alameda County? [ ] Yes [ ] No

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Name: ______________________________ D.O.B:_______________ M / F
Street Address: _____________________________ City: ___________ Zip: ________
Contact Numbers Home: _____________________ Cell: _____________________
Best Time to Call: ______________________ Language: _____________

Is client currently employed? [ ] Yes [ ] No
If NO are you receiving any unearned income [ ] Yes [ ] No
If Yes:____

Does client have private insurance or other health coverage? [ ] Yes [ ] No
If Yes: _______________________

Notes:

***Some restrictions may apply to non-Alameda residents**

Tri-City Health Center (TCHC) is a **leading** community health services partner committed to meeting today's needs for **comprehensive, innovative, affordable,** and **culturally competent healthcare.**