HCP REFERRAL FORM

SOURCE INFORMATION		DATE:
Individual Completing Form:		**Organization & Title:**
Phone:	**Fax:**	**E-Mail:**

Care Coordination Needs: ☐Community-based Information/Resource ☐HCP Care Coordination

Reason for Referral:

Known Medical Conditions:

CLIENT INFORMATION		
Last Name:	**First:**	**Birth Date:**
Gender:	**Primary Language:**	**Insurance:**

CLIENT'S PHYSICIAN INFORMATION		
Primary Care Provider:	**Phone:**	**Fax:**

FAMILY MEMBER/GUARDIAN HOUSEHOLD INFORMATION	
Last Name:	**First:**

Relationship to Client: ☐Mother ☐Father ☐Grandparent ☐Legal Guardian ☐Foster-Parent ☐Other:

Primary Language Spoken:			**Interpreter Needed:** ☐Yes ☐No
Mailing Address:	Street:	Apt. #:	City: Zip Code:
County:	Alternate Address:		
Phone Number (preferred): ☐Home ☐Cell ☐Work		**Phone Number (alternate):** ☐Home ☐Cell ☐Work	
E-Mail:		**Family Notified of Referral:** ☐Yes ☐No	

Referral Sent to Local HCP Office For additional local public health agency contact info: www.hcpcolorado.org
Denver HCP: 303-602-6765 (p); 303-436-4798 (f) – Molly Benkert, RN
Jefferson County HCP: 303-239-7006 (p); 303-239-7088 (f)—Laureen Mooney
Tri-County HCP: 303-783-7139 (p); 303-761-1528 (f) – Carolyn Kwerneland, RN

Agency Name:	**Date Sent:**

HCP USE ONLY:
Referral Source Follow-up: ☐Verbal ☐E-mail ☐Referral Feedback Faxed **Date:**
CC Name: **CDS#:** **MR#:**