TIPs REFERRAL FORM

RETURN COMPLETED REFERRAL REQUEST FORM TO			
ATTENTION	SAC Connect Therapeutic Services	FAX	
PHONE		EMAIL	thesacconnect@gmail.com
FORM COMPLETED BY		PHONE	DATE

REFERRED BY			
REFERRING AGENT		PHONE	
SPECIALTY		FAX	
SIGNATURE (electronic ok)		EMAIL	

CLIENT INFORMATION			
LAST NAME		FIRST NAME AND MI	
DATE OF BIRTH		FEMALE / MALE	
INTERPRETER REQUIRED?		LANGUAGE REQUIRED	
CLIENT'S ADDRESS		CELL PHONE	
		HOME PHONE	
		EMAIL	

SERVICE REQUESTED				
REASON FOR REFERRAL				
PATIENT AWARE OF REASON FOR REFERRAL? IF NOT, PLEASE EXPLAIN.				
SERVICE / SPECIALTY REQUESTED				
TYPE OF SERVICE REQUESTED		CASE MANAGEMENT		CRISIS INTERVENTION new client evaluation / management
ADDITIONAL COMMENTS				

CONSENT TO RELEASE REFERRAL INFORMATION (read with client and answer any questions before the client signs below)

I, _____(referring party), understand that the purpose of the referral and of disclosing this information to the SAC Connect Therapeutic and Wellness Services is to ensure the safety and continuity of care among service providers seeking to serve this individual/family. The referral process has clearly been explained to me, that _____ (client name) will be contacted, and the above information will be disclosed to serve the client.