REFERRAL FORM

Complete all requested information and submit by fax: 704-237-8797. Please inform client that we will be contacting them concerning the requested service. We will notify referring agency once referral is completed.

REFERRER INFORMATION

Agency Name: _____ Phone: _____

Referring Person Name: _____ Phone: _____ Fax: _____

ID Dr. Name/Clinic: _____ Phone: _____

CLIENT INFORMATION

Client Name: _____ Date of Birth: ___/___/___

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: _____ Cell Phone: _____

Race: _____ Gender: _____ Preferred Noun: _____

SERVICE REQUESTED *(Please check all that apply)*

☐ HIV Support Group ☐ Toiletries ☐ PrEP Program ☐ Housing Dept. STRMU Assistance

Is client aware of referral? ☐ **Yes** ☐ **No**

REASON FOR REFERRAL:

_____

_____

_____