Interagency Referral between CRF, ECMH, MITE, NHcare and Vista Hill Parent Care

Client Information

Name: _____ **Quadrant: I II III IV**

Address: _____ **Phone** _____

Primary Language: English Spanish Arabic Other_____ **DOB:** _____ **Age:**_____

Referred by: CRF ECMH MITE NHcare VHPC **Referred to:** CRF ECMH MITE NHcare VHPC

Section Below to be Completed by Referring Party

1. The reason/hoped for result for this referral is: (consult, diagnosis, treatment, etc.)

2. The individual is reporting the following medication(s): (dosages and frequency)

3. The individual is being treated/has in their history the following problem(s) and /or diagnoses:

4. Description of any special concerns and/or other care providers:

Referred by	Date:
Title/discipline	
Phone:	Fax:
Email:	

Section Below to be Completed by Receiving Party

Date client seen:	Client is scheduled to return:
Treatment plan:	
Additional information to follow Yes No If requested	
Seen by:	
Title/discipline	
Phone	Fax:
Email:	