REFERRAL TO COMMUNITY HOUSECALLS Program

Harborview Medical Center, Seattle, WA

Please fax to Interpreter Services 206-744-9981, attention: RN3 and send original to medical records

Name _____ Language: _____

Religious/Ethnic information: _____

Current Phone: _____ Address:_____

Name of other household members (if relevant) Relationship to patient

_____ _____

_____ _____

_____ _____

_____ _____

For: ☐ Short term issue ☐ Long term care coordination

Priority status: ☐ High (contact within 3 working days) ☐ Medium (within 1 week) ☐ Low (within 2 wks)

Reason for referral: _____

_____

What do you want assessed: _____

_____

What action do you want taken? _____

_____

Other current issues:	**Medical:**			**Social:**
___Hypertention	___ Family Planning	___Failure to thrive	___ Financial	___Domestic Violence
___ Asthma	___ Pregnancy	___ Anemia	___ Housing	___ Headstart
___ Diabetes	___ Headache	___Immunization	___ESL	___Transportation
___ Seizures	___ Backache	___Nutrition	___Citizenship	___Employment
___Cancer	___Substance Abuse	___Child Abuse	___Immigration	___Family Conflict
___ HIV	___Depression	___PTSD		

Other:_____

Comments: _____

_____

Primary Care Provider: _____

Name/Title of person making the referral: _____

Phone: _____ Fax: _____ Email:_____ Mailbox _____

Was referral discussed with family? ☐ Yes ☐ No

Signature: _____ Date: _____

UNIVERSITY OF WASHINGTON MEDICAL CENTERS
HARBORVIEW MEDICAL CENTER - UW MEDICAL CENTER
SEATTLE, WASHINGTON
REFERRAL COMMUNITY HOUSECALLS
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