Referral Form

Referral Program (Prioritize options 1-7)

Date: ______________________

☐ Thurston County Project Access ☐ Sea Mar Community Health Center

☐ Mental Health Access Program ☐ Emergency Department Consistent Care Program

☐ OUGM Dental Clinic ☐ OUGM Vision Clinic ☐ OUGM Chronic Disease Clinic ☐ Other

Client Information

Client Name: ____ Date of Birth: ____________________

First Middle Last

Gender: M F Phone #: ______________________________ Can we leave messages on this phone? Y N

Household gross monthly income: ________________ Residence: ______________________________

Town County

Number of individuals in household: ____________________

Insurance: ☐ Uninsured ☐ Underinsured ☐ Other: ____

I agree that my personal that my personal health information may be shared with the safety net programs (listed above) in order to determine eligibility and coordinate services. This personal health information may include medical records or data obtained regarding any present/past physical or mental health conditions as well as information pertaining to drug or alcohol use of other social issues that may affect my treatment. In addition, it may include any observations, concerns, or recommendations of the person or agency referring me to the safety net program or programs I am being referred (listed above).

I understand that my referral does not constitute/imply automatic enrollment in any of the above programs. Upon review of my referral for eligibility, I will be contacted by the program of choice regarding clinical visit or enrollment. A current picture ID will be required. Verification of income or residence may be required.

Patient/Legal Guardian Signature: ______________________________ Date: ____________________

Referral Information

Referring Provider: ______________________________ Referring Organization: ____________________

Phone #: ________________________ Fax #: ____________________________

Please indicate the SPECIALTY you are referring this patient to:

Updated 8/10/2010

Current chief complaint (onset, symptoms, behavior, self-harm ideation) and brief description of medical reason for this referral:

Pertinent Medical, Mental Health or Physical History:

Patient's primary care provider/dental provider: ______________________________

When was last visit? ______________________________

How urgent is this referral? 1 2 3 (circle one)

1=Should be addressed within 2 weeks
2=Should be addressed within 4 weeks
3=Should be addressed within 8 weeks

Please describe any pertinent social history:

Does the client have any history of sexual offense or violent behavior?

☐ Yes ☐ No ☐ Unknown

Medications: (please list ALL current medication and newly prescribed medications)

Medication	Purpose	Dosage	Frequency	Approx. Date Prescribed	Who Prescribed?

Emergency department visits for prior 12 months (by month, if possible):

Please fax completed form and medical records to appropriate program (fax numbers listed below).

Olympia Union Gospel Mission
Main: (360) 709-9725
Fax: (360) 570-8848
413 Franklin St NE, Olympia, WA 98501

Emergency Dept. Consistent Care
Main: (360) 493-5712
Fax: (360) 493-7708
2409 Pacific Ave SE, Olympia WA 98501

Mental Health Access Program
Main: (360) 493-5561
Fax: (360) 493-7708
2409 Pacific Ave SE, Olympia WA 98501

Thurston County Project Access
Main: (360) 493-4550
Fax: (360) 493-7708
2409 Pacific Ave SE, Olympia WA 98501

Sea Mar Community Health Center
Main: (360) 704-2908
Fax: (360) 704-7573
3030 Limited Lane NW
Olympia WA 98502