Harm Reduction Health

CLIENT REFERRAL FORM

- Referring organizations: please fill out Part A and ask client to take it to the receiving organization.
- Please fill out one form per service needed.
- Receiving organization: please fill out Part B and either return it directly to the referring organization or ask the client to return it to the referring organization at the next visit. Include relevant copies of any labs or reports that would help deliver comprehensive care to the client.

PART A: Referral Slip: To be filled out by the organization making the referral (referring organization)	
Date:	
Client Name:	Date of Birth:
Referred from: **South Jersey AIDS Alliance – Oasis Center**	
ARCH Nurse: **Babette Richter, RN**	Organization: **SJAA**
Address/phone number: **609/572-1929**	
Referred to:	
Contact person: **Carmen Lorenzo, PrEP Counselor**	Organization: **AtlantiCare**
Address/phone number: **1925 Pacific Ave, Atlantic City, NJ 08401**	
Hours of Operation: **9:00am-6:00pm M-Th**	**609-350-9714**

Services Needed/notes:

Client has reported high risk sexual activity. Client tested non-reactive for HIV 1/2 Ag/Ab on a Determine HIV test today. Referral is for PrEP education, screening and potential participation in PrEP medication treatment program.

NJDOH

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Part B: Services Provided: To be filled out by the organization fulfilling the referral	
Date:	
Client ID:	**Date of Birth**:
Services Provided: o Services Provided: _____ _____ _____ _____ o Services completed as requested _____ Yes _____ No o Follow-up needed: services: _____ _____ _____ Date for follow-up: _____	
Referred to:	
Contact person:	Organization:
Address/phone number:	
Hours of Operation	
Additional Comments:	

South Jersey AIDS Alliance

Authorization for Release of Information/Consent to Receive Information