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:	
ARCH Nurse:	Organization:
Address/phone number:	
Referred to:	Date of Birth:
Contact person:	Organization:
Address/phone number:	
Hours of Operation:	

Services Needed/notes:

Harm Reduction Health

Part B: Services Provided: To be filled out by the organization fulfilling the referral

Date:	
Client Name:	**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:	