

Date of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Care Nav Referral Form**

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| *CONTACT INFORMATION* |
| ***Name:*** | ***DOB:*** | ***Preferred Language:*** |
| ***Phone Number:*** | ***Email(s):*** | ***Preferred Contact Method:***☐ Phone Call ☐ Text ☐ Email  |
| ***Address:*** | ***Zip code:*** | ***County/Jurisdiction:*** |
| ***Parent/Guardian Name(s) and Phone Number(s) (if applicable):*** |
| ***Referral Source (Self, Formal/Professional Support, Mental Health Services, Outpatient, etc.) (if applicable):*** |

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| ***REASON FOR SERVICES*** |
| **Reason for Service/Service(s) Requested:** | [ ]  Mental Health/Care[ ]  Substance Use Disorder (SUD)[ ]  ER/Crisis[ ]  Challenging Behaviors[ ]  Family Support[ ]  Other: | If checked “other”, please explain: |
| **Are you currently enrolled in any other services?** | [ ]  Yes | [ ]  No | If yes, what services? |
| **Have you used/accessed any other services in the past?** | [ ]  Yes | [ ]  No | If yes, what services? |
| **Do you currently have health insurance?** | [ ]  Yes | [ ]  No | If yes, what insurance? |
| **Where do you currently access healthcare (PCP, urgent care, emergency visits, etc.)?** |  |
| **Do you need any special accommodation(s)?** | [ ]  Yes | [ ]  No | If yes, what accommodation(s)?  |
| **Do you currently have transportation?** | [ ]  Yes | [ ]  No | If yes, what transportation utilized (Car, bus, etc.)? |
| **Please list any additional information/barriers:** |  |