HEALTH NAVIGATION REFERRAL FORM

REFERRAL INFORMATION

Referred by: ____ Date: _____________

☐ Main Jail ☐ RCCC

Anticipated Release Date (If known): ______________

*PATIENT/FAMILY INFORMATION (required information)

First Name: _____________________ Middle: _____________ Last: ________________________

DOB: ____________ Preferred Language: ______________________________

Phone: ___________ SSN: _______________

ASSISTANCE NEEDED:

☐Health coverage enrollment ☐Find/Change doctor ☐Find/Change dentist ☐Find Vision ☐Interpretation

☐Transportation ☐Food/Nutrition ☐Inter-County Transfer ☐MAT Date started ________________

☐Other (please specify): ____

TYPE OF HEALTH COVERAGE

☐Medi-Cal, please enter the BIC number (if available): ________________________

Clinic Assignment (if available):_____________________Health Plan (if available) ________________

☐Medicare

☐Uninsured

☐Other: ____

ADDITIONAL INFORMATION

☐ Current Medications (if available) ____

☐ Mental Health Diagnosis (if available): ______________________________________

☐ Medical Diagnosis (if available): ____

☐ Probation_______________________ ☐ Parole _____________________

Questions? Call us toll-free: (916) 414-8333