COLORADO
Department of Public Health & Environment

HCP Referral Form

REFERRAL CONTACT INFORMATION		DATE:
Name/ Title:	**Organization & Department:**	
Phone:	**Fax:**	**E-Mail:**

FOLLOW-UP CONTACT INFORMATION		
Name / Title:	**Phone:**	**Fax:**
Organization & Department:		

REASON FOR REFERRAL

CLIENT INFORMATION		
Last Name:	**First:**	**Middle:**
Birth date:	**Known Medical Conditions:**	
Gender:		
Primary Care Provider (if known):	**Phone:**	

FAMILY MEMBER/GUARDIAN/HOUSEHOLD INFORMATION		
Last Name:	**First:**	**Middle:**

Relationship to client: ☐ Mother ☐ Father ☐ Grandparent ☐ Sibling ☐ Legal Guardian ☐ Step-parent
☐ Foster-parent ☐ Friend ☐ Don't Know ☐ Refused ☐ Other

Language Spoken: **Interpreter Needed:** ☐ Yes ☐ No

Mailing Address:	Street:	City:	State:	Zip:	County:

Phone Number (preferred): ☐ home ☐ cell ☐ work	**Phone Number (alternate):** ☐ home ☐ cell ☐ work
E-mail:	

COMMENTS / ADDITIONAL INFORMATION

ATTACHMENTS
Please attach pertinent medical records to this referral, if available. Number of pages attached: ___
☐ Consent & Release of Information ☐ Medical Records ☐ Care Plan
☐ Other:

HCP CONTACT INFORMATION		For local public health agency contact information, please see www.hcpcolorado.org.
☐ **Referral Sent to HCP**	**Date sent:**	**HCP Agency:**
HCP Contact:		**Email:**

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Phone:		**Fax:**
REFERRAL FEEDBACK LOOP (HCP to provide the following information back to the Primary Contact) **Assigned to:**		
Name & Title:		Organization:
Phone:	Fax:	E-Mail:

☐ Unable to Reach ☐ Family Refused ☐ Enrolled in HCP Care Coordination (Date: _____)

If enrolled in HCP Care Coordination, forward the following information to the Primary Contact:

☐ HCP Consent & Release of Information ☐ HCP Plan of Care (attached)

☐ Other: _____