Client Referral Form

Please fill in the blanks were applicable

Applicant Information		
Has clients rights, responsibilities and release of information been clearly explained to client?		
Name:		
Date of Birth:	Gender:	Phone:
Current Address:		
City:	State:	Zip:
County:	Primary Language:	
Does Client have Medicare?	Yes ☐	No ☐
Does Client have Medicaid?	Yes ☐	No ☐
Does Client have a Social Security Number? Yes ☐		No ☐
Does Client Have Legal Guardian? (if applicable) Yes ☐	No ☐	N/A ☐
Has Client been discharged from a hospital or nursing facility? (if yes please include release date)		
Yes ☐	No ☐	Release Date
Referring Agency		
Agency:		
Agent:		
Phone:	Email:	Fax:
Referral Date:		
Emergency Contact		
Name of a person not residing with you:		
Address:		
City:	State:	Zip:
Relationship:		
Services		
Current services client is receiving from your agency:		
Services client is requesting:		
Additional Comments:		
Client Consent		
Has client consented to release information between community partners? Yes ☐ No ☐		
Has client received and signed HIPPA privacy information acknowledgment form? Yes ☐ No ☐		
This section is to be completed by receiving agency and to be returned to Referring Agency within 30 days of initial referral		
Agency:	Agent:	Phone:
Case Status:		

Please Email Referral form to Sohnna.williams@wtcmhmr.org
Or
Print and fax this form to (432) 264-3295 (Attention: ADRC Staff)