

Patient Referral Form Formulario De Referencia Del Paciente



Valle del Sol
COMMUNITY HEALTH

School Representative Information			
Referral Date:	Click here to enter a date.	School Patient Attends:(If applicable)	Click here to enter text.
Name of Person Referring Patient:	Click here to enter text.	Phone # and Email:	Click here to enter text.
Student/Patient Information-Información Del Estudiante/Paciente <input type="checkbox"/> <u>Check if this is a teacher referral</u>			
Name/Nombre:	Click here to enter text.	DOB/Fecha de Nacimiento:	Click here to enter text.
Sex/Sexo:	Click here to enter text.	Grade Level/Nivel De Grado:	Click here to enter text.
Address/Dirección:		Telephone#/ # de Telefono	Click here to enter text.
Parent/Guardian Information-Información sobre el padre/guardián:			
Name/Nombre:	Click here to enter text.	Language/Lenguaje	Click here to enter text.
Email/Correo Electrónico:	Click here to enter text.		
<p style="background-color: yellow;">Do you have sole legal decision making for your child?/ Tiene los derechos exclusivos de tomar decisiones legales sobre el paciente?</p> <p><input type="checkbox"/> Yes/Si <input type="checkbox"/> No If not, who?/Si no quien?:Click here to enter text.</p>			
<p>If you do not have sole legal decision making, do you have a power of attorney that is dated within the last six (6) months or court documentation? / Si no tiene derecho de tomar de decisiones legales sobre el paciente, tiene una carta poder fechada en los últimos 6 meses o documentación de la corte?</p> <p><input type="checkbox"/> Yes /Si <input type="checkbox"/> No</p>			
<p>Note/Nota: Legal Parents or Guardians must consent to enrollment/ El Padre/Guardian legal tiene que dar consentimiento a servicios.</p>			
Medical Insurance Information /Informacion de Seguro Medico			
<input type="checkbox"/> AHCCCS	<input type="checkbox"/> Comercial Insurance/Seguro Comercial	<input type="checkbox"/> Uninsured/Sin Seguro Medico	
Reason For Referral (To be Filled out by School/Community Representative)			
<p style="background-color: yellow;">Any current or recent history of the patient hurting themselves or hurting others? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>Please Scan and Email this form to SchoolOutreach@Valledelsol.com.</p> <p><i>Please include your school's name in the subject line.</i></p> <p>You can also outreach the School Based team at this email for any questions regarding referrals.</p>			

Patient Referral Form
Formulario De Referencia Del Paciente



Valle del Sol
COMMUNITY HEALTH