

CLIENT REFERRAL FORM

Regular referrals send via Fax to **213-383-4598** or
Email to jgallegos@healthcarerights.org

Urgent referrals: call Judy Gallegos, Intake Coordinator at **213-383-4519 x 3002**

CLIENT NAME _____

ADDRESS _____

CITY _____ ZIP _____

PHONE # _____

EMAIL _____

BEST WAY TO CONTACT Phone Email

PRIMARY LANGUAGE

English

Spanish

Other

Check if Primary Contact

CONTACT NAME _____ PHONE # _____

RELATIONSHIP _____ EMAIL _____

PRIMARY LANGUAGE English Spanish Other _____

BEST WAY TO CONTACT Phone Email

REASON FOR REFERRAL

MEDICARE

PART D

MEDI-CAL

OTHER _____

PROVIDE BRIEF DESCRIPTION OF CLIENT'S QUESTIONS OR PROBLEM
