



Patient Referral to Project Health

Date: _____

New Patient Existing PH Patient

Patients can be referred by any existing doctor or clinic, or an emergency room doctor or social worker. They must be 18 years old or older and a Marion County resident.

Patient First Name (please print) Last name Age: Date of Birth: Sex

Patient SS# _____ Height: _____ Weight: _____

Street Address Apt # City Zip

Home phone: _____ Work Phone: _____ Cell Phone: _____ Pager: _____

Best time of day to contact patient: ___ Anytime ___ Mornings ___ Afternoons ___ Evenings

WHAT LANGUAGE DOES THE PATIENT SPEAK? ___ ENGLISH ___ SPANISH OTHER _____

DOES THE PATIENT NEED AN INTERPRETER? ___ YES ___ NO

CURRENT PRIMARY CARE DOCTOR _____ **PHONE** _____

CLINICAL REASON FOR REFERRAL

DOES PATIENT NEED TO SEE A SPECIALIST? ___ YES ___ NO **DIAGNOSIS CODE:** _____

IF YES, WHAT KIND OF SPECIALIST ?

- Please fax all pertinent labs and reports if they are available to Project Health along with this request.
- If the patient needs a surgical procedure please call the Project Health case manager at 262-5626 or 262-5657 .
- If the patient needs a complicated diagnostic procedure that is not done in your office, also call the case manager who will advise you where to send the patient.

SENT BY NAME: _____ **PHONE NUMBER & EXTENSION** _____

___ Primary Care Doctor ___ Nurse ___ Specialty Doctor ___ Other
___ ER Doctor ___ Social Worker ___ ECCO

REFERRED BY:

Physician/Nurse or Social Worker Name (print) Practice/Clinic or Hospital Name

Phone FAX E-mail

FAX THIS FORM TO PROJECT HEALTH AT 262-5609
QUESTIONS? – Call 262-5626 or 262-5627 for a Project Health Case Manager