Rockdale Coalition for Children and Families

HEALTH SAFETYNET

770-378-3134 CELL
sandra@rockdalecoalition.org

REFERRAL FORM

Today's Date: _____

Referring Agency:

_____Conyers Housing Authority
_____EMS/CPP
_____Family Promise
_____Helping Hands
_____ Mercy Heart
_____ New Directions
_____ MedCura Health
_____Phoenix Pass
_____Project-Renewal
_____RCPS
_____PRMC-ER/ Case Manager
_____Rockdale Health Department
_____Rockdale House (Men & Women)
_____ Rockdale DFCS
_____ View Point Health
_____Other
_____Unidos Latino Association
____ RER

Name: Last:	**First:**	**Middle:**

Date of Birth: **Age:** ☐ **F** ☐ **M** **Race:** **Marital Status:**

Address:	**City:**	**State:**	**Zip code**
	Conyers	**GA**	

Home Phone:
Work Phone:
Cell Phone:
Email:

Other Information:
Income:
Education:
Employment:
Doctor:

Reason for referral:

Medical____ Dental____ Vision____ Hearing_____

Behavioral Health____ Prescription Assistance_____ Other_____

For Coalition office use:

Date received:
Disposition & Completion date:

Person completing the referral form, please provide as much information as possible regarding the need and sign below.

Person is in agreement for this referral to be made to The Rockdale Coalition Health SafetyNet Coordinator via any electronic method that may be unencrypted. This may be shared with medical personnel in order to obtain medical care.

Patient Signature **Date** **Referrer Signature** **Phone** **Date**