HEAL REFERRAL INFORMATION SHEET

Date of Referral: _____________________

Referring Provider/Agency: ____

Client Information

Name: ____

Date of Birth: ____

Safe Phone Number: ____

Is it safe to leave a message at this number: □YES □ NO

Best time to reach client: ____________________________________

Address: ____

Is it safe to send mail to this address: □YES □ NO

Has client given consent to be contacted by HEAL staff: □YES □ NO

Insurance Information (if available)

Insurance: ____

Insurance ID Number: _______________________________________

**** If clients prefer not to be contacted by staff members, please encourage them to reach out directly to 585-275-HEAL (4325) ****