



# I-CAN CLIENT REFERRAL FORM

(please download and open form from you desktop before filling out)

Date: \_\_\_\_\_

## REFERRER INFORMATION

Agency:	Name:
Phone:	Email:

## CLIENT INFORMATION (one client per form please)

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.	Name:
Phone:	Email:
Spoken Language:	<input type="checkbox"/> Client is an immigrant/refugee
Address/Location:	
Tips for Contacting:	

### Reason(s) for referral:

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> 2+ non-acute EMS calls in 6 months</li> <li><input type="checkbox"/> 3+ missed medical appointments in 6 months</li> <li><input type="checkbox"/> 10+ prescribed medications</li> <li><input type="checkbox"/> Lack of primary care home</li> <li><input type="checkbox"/> Lack of health care insurance</li> <li><input type="checkbox"/> Lack of stable housing</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> 5+ unexcused child school absences</li> <li><input type="checkbox"/> 2+ family members with a disabling or uncontrolled chronic illness</li> <li><input type="checkbox"/> 1+ developmentally delayed parent</li> <li><input type="checkbox"/> Concerns for child health and wellness</li> <li><input type="checkbox"/> Other <small>(please specify below)</small></li> </ul> |
|--|---|

### Brief description of client's background, needs/goals, or other additional information: (required)

Questions? Email us at: [ican@ohsu.edu](mailto:ican@ohsu.edu)