OHSU I-CAN INTERPROFESSIONAL CARE ACCESS NETWORK

Date: _____

I-CAN CLIENT REFERRAL FORM

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

REFERRER INFORMATION

Agency:	Name:
Phone:	Email:

CLIENT INFORMATION (one client per form please)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.	Name:
Phone:	Email:
Spoken Language:	☐ Client is an immigrant/refugee
Address/Location:	
Tips for Contacting:	

Reason(s) for referral:

- ☐ 2+ non-acute EMS calls in 6 months
- ☐ 3+ missed medical appointments in 6 months
- ☐ 10+ prescribed medications
- ☐ Lack of primary care home
- ☐ Lack of health care insurance
- ☐ Lack of stable housing
- ☐ 5+ unexcused child school absences
- ☐ 2+ family members with a disabling or uncontrolled chronic illness
- ☐ 1+ developmentally delayed parent
- ☐ Concerns for child health and wellness
- ☐ Other (please specify below)

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

Submit form to I-CAN

Questions? Email us at: ican@ohsu.edu