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Referral Form

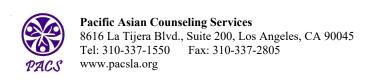
Thank you for your interest in requesting services.

Please take a moment to complete the following information and email it to <u>referrals@pacsla.org</u> and someone will contact you.

If this is an emergency, please call 911 or go to your nearest hospital emergency room.

Patient Information						
Last Name First		rst Name		Middle Name		
Current Address		City		State Zip Code		
Cell Phone	Work Phone	Home	Phone	Other P	none	
Can we leave a message?	Yes No	Good Time to ca	ll back?			
Birth Date:	Ge	nder: Male	Female	Other		
Do you speak English? 🗌 Y	Yes No					
Preferred Language: Cantonese Cambodian English Japanese What is your ethnicity? African - American/Black Asian:	🔲 W	Taiwan Vietnan Other: ative American hite/Caucasian	mese	refer not to sta		
☐ Latino/Hispanic Marital Status: ☐ Never M	_	her: Widowed	☐ Divorced	l □ Sep	parated	
Do you have medical cover		cial Information	1			
		G 1M			20	
Insurer's Name		ance Card No.		Issue/Ei	fective Date	
Are you requesting services If yes, please comple		s No				
Contact/Reque	estor's Name		Contact/Requ	estor's Phon	e number	

Rev Date: 2021-11-01



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	e client aware of this referral? Yealescribe reason for seeking services:	s 🗌 No	Can we contact the client? \(\subseteq \text{Yes} \)	□ No
When di	d you start experiencing this problem	i?		
П	i	4.:	□No	
	you previously received services for t		_	
Have	you ever been hospitalized and/or jail	led due to your men	tal health? Yes No	
Are yo	ou currently taking medications for yo	our mental health? [Yes No	
Are yo	ou in urgent need of medication refills	s? 🗌 Yes 🔲 No		
**	*********	<**************	*********	****
•		Thank You!		