CHI St. Vincent

MEDICAL-LEGAL PARTNERSHIP REFERRAL FORM

Referral Date: _____ **Referral Source(s):** _____

Referred Person's Provider Name: _____

Name of Referred Person: _____ **DOB:** _____

Referred Person's Relationship to CHI St. Vincent (circle one):

Patient, Parent of Patient, Sibling of Patient, Friend of Patient, Representative of Patient, Other: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Primary Phone #: _____ **Secondary Phone #:** _____

Is it okay to leave a message at the number(s) provided? Yes No

Reason for Referral (check all that apply):

- ☐ SNAP/WIC/TEA
- ☐ Medicaid/Medicare/Other Health Insurance
- ☐ Education
- ☐ Family Law (Guardianship/Custody/Divorce)
- ☐ Domestic Violence
- ☐ Advance Directive/Wills/Power of Attorney
- ☐ Disability (SSI/SSDI/ADA)
- ☐ Immigration
- ☐ Employment/Medical Leave
- ☐ Housing (Condition/Utilities/Eviction/Foreclosure)
- ☐ Debt Collectors
- ☐ Food Stamps
- ☐ Veteran's Benefits
- ☐ Small Claims Court
- ☐ Clean up Criminal Record
- ☐ Child Support
- ☐ Stop Physical, Mental or Sexual Abuse
- ☐ Other (please specify): _____

Language: English Spanish Other: _____

Referral source requests to be contacted when an update is available: Yes No

Referral source name and telephone number:

_____

Additional Information for Attorney:

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