Free Clinic
OF SOUTHWEST WASHINGTON

Project Access

Medical Referral Form

Date_____

PATIENT INFORMATION		
Name:		
Date of Birth:		
Address:		
Home Phone:	Cell Phone:	Work Phone:
Message/Answer Service:		
Alternate Contact:	Patient's Primary Spoken Language:	
Phone# of Contact:	Interpreter Needed? ☐ YES ☐ NO	

Specialist Needed: _____

Reason for Referral:_____

_____

Patient Eligible for the Health Benefit Exchange? ☐ No ☐ yes

Chart Notes, Imaging, Labs, EKG, and Studies: ☐ Are attached ☐ Will follow

☐ Hospital ☐ Any previous consult reports

REFERRING PROVIDER INFORMATION	
Referring Provider:	Circle: MD/DO/PA/NP
Clinic Name:	Physician Contact Phone:
Clinic Physical Address:	Clinic Mailing Address:
Clinical Referral Coordinator:	Phone#:
Fax#:	Referral Coordinator E-Mail:

Provider Signature _____MD/DO/PA/NP