78365 Highway 111, Suite 208
La Quinta, CA 92253
P: 760.618.1528
F: 888.783.7618
E: admin@theeight.org
W: www.theeight501c3.org

CLIENT REFERRAL

Client's Name: ____ **Date of Referral:** __________________

ID#: ____ **Address:** _______________________

Birthdate: ____ ____________________________________

Telephone #: ____ ____________________________________

Referral To: *Service Provider's Name, Address, Telephone #*

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Reason For Referral: ____

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Authorization: I, ____[Client Name], give my permission to ____[Care Coordination Provider's Name]. The information is to be used to assist me in monitoring and coordinating my healthcare and social service needs. I believe in order to be truly "well" in all areas of my life; the 8 Dimensions of Wellness (Physical, Emotional, Environmental, Social, Intellectual, Occupational, Financial, and Spiritual) need to be equally address to assure proper balance.

Signature of Client/Parent or Guardian: ____

Date:__________________

Service Provider's Reply: (Summary of findings, recommendations, comments) _________________________________

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