



**Immigrant Health Access Program (IHAP)
Referral Form**

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***IHAP is a program for immigrants and refugees who live in Greensboro only.**

Agency Information

Date of referral: _____

Name (person completing form): _____

Phone number: _____ Fax number: _____

Agency: _____

Agency address: _____

Client Information

Name: _____ Date of birth: _____ Gender: _____

Address: _____

Home phone number: _____ Cell phone number: _____

Country of origin: _____ Preferred language: _____

Client speaks English: Yes No

Reason for Referral

Has your agency provided any initial interventions?

Yes No N/A

If yes, please specify: