*IHAP serves immigrants and refugees who live in* ***Greensboro only****. Languages available are**Spanish, French, Swahili, Kinyarwanda, Kirundi, Vietnamese, Jarai, Rhade.*

**To submit a referral,** please email this form to[**ihap@uncg.edu**](mailto:ihap@uncg.edu) or fax to **336-334-5413**.

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| **REFERRAL SOURCE INFORMATION** |
| **Date of Referral:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Name** *(person making referral):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Agency Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **CLIENT INFORMATION** |
| **Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender:** \_\_\_\_\_  **Home Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Alternate Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Country of Origin:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Arrival Date** *(if client is a refugee):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Preferred Language(s):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Client Speaks English:**  Yes  No  Some/Limited **Client Is Aware of Referral:**  Yes  No  **Family Members Need Assistance:**  Yes  No *(if yes, please attach a separate form for each, noting relationship)* |
| **HEALTH ACCESS INFORMATION** |
| **Insurance Status:**  Medicaid  Medicare  Private Insurance  Uninsured  Orange Card  **Primary Care Provider** *(if applicable)*: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| **REASON FOR REFERRAL** |
| **Has your agency provided any initial interventions?**  Yes  No *(if yes, please specify below)*  **Will your agency be providing any ongoing assistance?**  Yes  No *(if yes, please specify below)* |