REFERRAL

Prevention is the best medicine. Please remember to make your doctor's appointment for preventive exams.

Parent or Guardian _____
First *Middle* *Last*

Parent or Guardian Date of Birth _____ Spouse's Name _____

Mother's Maiden Name _____ Spouse's Date of Birth _____

Address _____

City _____ Zip _____

Telephone (_____) _____ Cell Phone (_____) _____

Language: ❑English ❑Spanish ❑Other: _____

Client's email: _____

Release Of Information:
I give my permission to have my family evaluated for all health care programs, such as Medi-Cal and /or other access to care programs.

_____ _____
Signature of parent or guardian *Date*

Please fill in the following information:

Referring Agency _____ Referring Person _____

Phone Number _____ Date of Referral _____

We will follow-up on the referral to setup an appointment with the client. **Please give us as much of the information possible.**

_____

_____

For Clinic / Hospital use
Was patient given
Presumptive Eligibility? Yes No

Expiration Date _____

VENTURA COUNTY
PUBLIC HEALTH

To better serve the community everyone is seen by appointment only.
Please fax all referrals to (805) 981-5387 attn: Rita
or
Email: rita.duarteweaver@ventura.org
If you have questions, please call (805) 981-5212

For Office Use: _____

_____ Apt. Date _____

_____ Time _____

_____ Location _____

_____