Referral Form
Please fill out completely and return to: Ted Jordan – Non-Medicaid Care Coordinator
Cell: 716-790-2529 Fax: 716-373-4604

1. Referral Information

Date: ________________
Person/Agency Referring:____
Phone Number: _____________________ Email:____

2. Consumer Information:

Name:	Date of Birth:	Gender:
Address: County:	Insurance:	
Phone:	Cell:	

3. Reason for Referral:

Is it safe for Home visits: Y __ N __

4. Diagnosis

Check	Category	Diagnosis
	Serious Mental Illness	
	HIV/AIDS & Risk of developing another chronic condition	
	Mental Health Condition	
	Substance Abuse Disorder	
	Asthma	
	Diabetes	

	Heart Disease	
	Other Chronic Condition (Specify)	