Community Health Worker Referral

Fax To: 888-393-9235

CareNET
TOLEDO/LUCAS COUNTY

Referring Clinic: _____ Phone # _____

Referring Staff Member: _____

Staff Member email address: _____

Patient Name: _____ Phone# _____

Address: _____ City: _____ Zip: _____

Date of Birth: _____

Insurance Status (please circle): **Uninsured** **Private Insurance** **Medicaid** **CareNet**

If insured (public/private), please list _____ (Carrier Name) _____ (Policy Number)

Please check any of the following areas the patient may need assistance with:

- ◊ Health Insurance/Medicaid Application
- ◊ Housing
- ◊ Food
- ◊ Clothing
- ◊ Utilities
- ◊ Access to Medication
- ◊ Taking Medication Correctly
- ◊ Frequent ER Visits
- ◊ Smoking Cessation
- ◊ Transportation
- ◊ Dental
- ◊ Housing
- ◊ Legal
- ◊ Specialty Care
- ◊ Domestic Violence
- ◊ Translation Assistance
- ◊ Other: _____

Any additional information regarding patient that may be helpful: _____

_____

_____

_____

Office Use Only:

Date Received: _____ Assigned To: _____ 1st Contact: _____

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