Social Services Referral Form

Patient: _____ *HS# or DOB _____

*Patient's Phone Number: _____

*Emergency Contact Name and Phone Number: _____

PCP's Name: _____

Please check all applicable:

☐ Severe medical and/or mental illness/ substance abuse with severe psychosocial vulnerability and decreased cognitive functioning

☐ Frequent inpatient admissions

☐ Lack of benefits/ services or exhaustion of benefits to support medical needs

☐ High rates of behavioral health utilization

☐ Decreased self-management behaviors

☐ Lack of community-based services:

☐ Living arrangement ☐ Food ☐ Financial needs ☐ Transportation

☐ Lack of social support (family/friends) ☐ Custodial needs

Comments: _____

_____

_____

_____

Referred by: _____ Date: _____

(Please email signed form to socialservices@healthsun.com or fax it to 786-507-5679)

***Important information**

Referrals from PCP's offices and Centers MUST include demographic information and last progress note with current meds.