GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HUMAN SERVICES

REFERRAL

Important --- Take this with you. Report to the following address at the time indicated below.

NAME			
P F NO.	BIRTH DATE	SEX M F	
SOURCE OF REFERRAL AND ADDRESS			
PATIENT'S ADDRESS		ZIP	
APT. NO.	CT	TELEPHONE NO.	
REASON FOR REFERRAL	CONTROL NO.		

FACILITY	
ADDRESS	
DATE	HOUR

SIGNATURE	TITLE	TELEPHONE NO.	DATE
☐ I HEREBY GIVE MY PERMISSION TO RELEASE MEDICAL INFORMATION FOR USE BY D.C. DEPARTMENT OF HUMAN SERVICES	SIGNATURE OF PATIENT, PARENT OR GUARDIAN		DATE

INSTRUCTIONS: PLEASE REPORT DIAGNOSIS AND TREATMENT BELOW, AND RETURN ONE COPY TO THE FACILITY WHICH MADE THE REFERRAL.

DIAGNOSIS AND TREATMENT: ______________________________

TREATMENT: ☐ COMPLETED ☐ UNCOMPLETED ☐ NOT INDICATED

SIGNATURE TITLE DATE