



<b>Referral From:</b> Name: _____ Agency: _____ Phone: _____ Email: _____
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# CLIENT REFERRAL FORM

Please use this referral form to refer clients who have Medicare, Medi-Cal or related health insurance problems. The referral should be sent to CHCR by secure email to [chcreferral@healthcarerights.org](mailto:chcreferral@healthcarerights.org) ; or by Fax to (213) 383-4598.

DATE: \_\_\_\_\_

### CLIENT INFORMATION

NAME (include middle initial/suffix, if applicable): \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

PRIMARY LANGUAGE: \_\_\_\_\_

Best Way to Contact:  Phone or  Email

CONTACT NAME: \_\_\_\_\_

PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

RELATIONSHIP TO CLIENT: \_\_\_\_\_

CONTACT'S PRIMARY LANGUAGE: \_\_\_\_\_

Best Way to Contact:  Phone or  Email

**REASON FOR REFERRAL:** Provide a brief description of the client's questions or concerns below.

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