TARZANA TREATMENT CENTERS, INC.
CLIENT REFERRAL SHEET
COMMUNITY PROGRAMS AND SERVICES

Program: ❑ Benefits Specialty ❑ Case Management ❑ Medical Case Management

Date: ________________

Name: ______________________________ Social Security Number: ____________________

Address: ______________________________ Date of Birth: ____________________

______________________________ Phone: ____________________

Gender: ___ Male ___ Female OK to leave message? Yes / No

___ TG/M-F ___ TG/F-M OK to mention "TTC"? Yes / No

Does individual have photo ID? Yes / No Primary language: ____________________

If yes what type? ______________________

Emergency contact name: ______________________ Relationship: ____________________

Phone: ______________________________

Primary physician name: ______________________________ Phone: ____________________

Clinic / Hospital: ______________________________ Phone: ____________________

Does Individual have diagnosis form? Yes/No

If "Yes", attach diagnosis form.

If "No", was client provided with a diagnosis form to be completed? Yes / No

Diagnosis (please check one): HIV + _____ AIDS: _____ Non Positive: _____

Does the individual currently have:

___ **SSDI** Yes / No / Pending ___ **Medicare** Yes / No / Pending

___ **SSI** Yes / No / Pending ___ **Medi-Cal** Yes / No / Pending

___ **GR** Yes / No / Pending ___ **ADAP** Yes / No / Pending

Is individual or has individual received services from TTC or any other agency? Yes / No

If "yes", describe where and when: ____

Referral Source / Name: ______________________________ Phone: ____________________

Agency: ______________________________ Referral form filled out by: ____________________

Notes: ____

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When Possible Please Attach the Following:

___ I.D. ___ Proof of Income

___ Current HIV Diagnosis Form ___ Proof of Residence

Office Use Only:

Individual has been assigned to:

______________________ ______________ & ______________________ ______________

Staff **Date** **Staff** **Date**