Client Referral Form

To:	Big Bend Regional Hospital District	Fax:	432-837-3261
From:		Phone:	

Client Information

Client name:	Phone Number:
County of Residence: ☐ Brewster ☐ Presidio	Client Primary Language: ☐ English ☐ Spanish ☐ Other:

Reason for referral

Services needed:

☐ Medical Plan	Assistance paying for preventative and emergency medical care, includes medications
☐ Dental	Preventative and emergency dental assistance
☐ Vision	Preventative vision assistance
☐ RX Grant	Assistance in applying for Patient Assistance Programs directly through drug manufacturers
☐ Prescription Plan	Medication coverage for Medicare recipients
☐ Transportation Assistance	Transportation assistance for medical appointments
☐ Medical case management	Assistance in coordinating and scheduling medical appointments

I, ________________________________, understand that the information provided on this form will be released to Big Bend Regional Hospital District. I give my permission for this referral to be made and information to be released. I understand that this information is confidential.

________________________________ ________________________

(Client signature) (Date)