



SUPPORT SERVICES
HEALTHCARE PROFESSIONAL REFERRAL FORM

PLEASE NOTE: If a patient is in imminent danger of harming themselves or others or is at risk of abuse or neglect, please call 911, in addition to completing this form.

Date: _____

Patient Name: _____

Phone: _____

Is patient aware of referral? Yes No

Reason for Referral

Please include all information you think would be helpful.

Name of Referring Healthcare Professional: _____

Phone: _____ E-mail: _____

A Social Worker will contact the patient during regular office hours, within 48 hours of this referral, unless otherwise noted. Social workers can evaluate and provide counseling for: depression, anxiety and adjustment disorders. Social workers can also assist patients in obtaining insurance, financial assistance, home care and other social needs. We will contact you after we have spoken with the patient and after we have obtained their permission to disclose information concerning their medical records, according to HIPAA Regulations (see below).

Please fax or email this form to the Support Services Department:

(805)569-7715 fax
SupportServices@ccsb.org

HIPAA REGULATIONS:

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose patients' individually identifiable health information except as provided in our Notice of Privacy Practices without their authorization.