GDAHA
GREATER DAYTON AREA HOSPITAL ASSOCIATION

Dayton Regional Pathways HUB

# REFERRAL FORM

## CLIENT INFORMATION

| NAME: | DATE OF BIRTH: | RACE/ETHNICITY: |
|---|---|---|
| ADDRESS: | | |
| CITY: | STATE: | ZIP: |
| PHONE NUMBER (REQUIRED): | EMAIL ADDRESS: | |

## REFERRED BY

| NAME: | AGENCY: |
|---|---|
| PHONE: EXT: | EMAIL: |

## PLEASE CHECK ALL FACTORS THAT APPLY

- ◯ ALCOHOL / SUBSTANCE ABUSE
- ◯ CHILDCARE
- ◯ CLOTHING
- ◯ DOMESTIC VIOLENCE
- ◯ EDUCATION
- ◯ FAMILY HISTORY OF HEART DISEASE/DIABETES
- ◯ FINANCIAL ASSISTANCE
- ◯ FOOD
- ◯ HOUSING
- ◯ INSURANCE
- ◯ EMPLOYMENT
- ◯ LEGAL
- ◯ LOW INCOME
- ◯ MEDICATION ASSISTANCE
- ◯ MENTAL HEALTH
- ◯ OBESE
- ◯ PHYSICALLY INACTIVE
- ◯ POOR DIET
- ◯ SMOKER/TOBACCO USER
- ◯ STRESS
- ◯ TRANSPORTATION
- ◯ OTHER
  - EXPLAIN/DESCRIBE
- ◯ PREGNANT
  - ENTER DUE DATE GRAVIDA/PARA:

## INSURANCE STATUS

| INSURANCE PROVIDER: |
|---|
| |
| MEMBER #: |
| |

- ◯ MEDICARE
- ◯ UNINSURED

## PLEASE PROVIDE ANY ADDITIONAL INFORMATION THAT MAY BE HELPFUL

**FAX REFERRAL TO 937-228-1035 OR EMAIL: DAYTONHUB@GDAHA.ORG**