

The Peninsula Family Advocacy Program

A Medical-Legal Partnership for Children

REFERRAL SOURCE

Provider's Name:	Child's Name:
Parent's Name:	Child's Date of Birth:
Type of Provider:	Family's Phone #:
Provider Phone #:	Other Contact #:
Provider Pager #:	Okay to Leave Message?: Yes No
Consultation Date:	Preferred Language:
Family lives in City:	County:
Zip Code:	

PRESENTING PROBLEM(S) (check all that apply)

- Health Insurance
- Medical Bills
- Housing Problems
- Disability Benefits
- Welfare
- Food Stamps
- WIC
- Employment

- Domestic Violence
- Child Abuse or Neglect
- Child Support
- Child Custody/Visitation
- Guardianship
- Immigration
- Special Education
- Other: _____

I, _____, authorize the Family Advocacy Program to notify the clinician listed on this form that I have had a consultation with the Family Advocacy Program and whether FAP was able to help resolve my problem or refer me to other resources. I also authorize the Family Advocacy Program to notify my clinician if the Program is unable to contact me.


Patient/Representative Signature

Date

Provider Signature

Please fax to:

Francisca Guzman, Family Advocacy Program,
Fax Number: (650) 558-0673. If possible, please leave a voicemail explanation at: (650) 645-1704. Thank you!


LEGAL AID SOCIETY
 OF SAN MATEO COUNTY
 521 East 5th Avenue
 San Mateo, CA 94402
 Lauren Zorfias, Executive Director

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- | | |
|---|--|
| <input type="checkbox"/> Health Insurance
<input type="checkbox"/> Medical Bills
<input type="checkbox"/> Housing Problems
<input type="checkbox"/> Disability Benefits
<input type="checkbox"/> Welfare
<input type="checkbox"/> Food Stamps
<input type="checkbox"/> WIC
<input type="checkbox"/> Employment | <input type="checkbox"/> Domestic Violence
<input type="checkbox"/> Child Abuse or Neglect
<input type="checkbox"/> Child Support
<input type="checkbox"/> Child Custody/Visitation
<input type="checkbox"/> Guardianship
<input type="checkbox"/> Immigration
<input type="checkbox"/> Special Education
<input type="checkbox"/> Other: _____ |
|---|--|

Yo, _____, autorizo que el Programa de Abogacía para Familias avise al proveedor de servicios de salud (el nombre de quien está escrito en este formulario) que he tenido una consulta con el Programa de Abogacía para Familias y si el Programa fue capaz de ayudarme a resolver el problema o referirme a otros recursos. También autorizo que el Programa de Abogacía para Familias avise mi proveedor de servicios de salud si el Programa no puede contactarme.

Firma del Paciente/Representante

Fecha

Provider Signature

Please fax to:

Francisca Guzman, Family Advocacy Program,

Fax Number: (650) 558-0673. If possible, please leave a voicemail explanation at: (650) 645-1704. Thank you!

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Form updated February 2011.