

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
Provider Fax #:	Preferred Language:
Consultation Date:	Patient's Next Clinic Appt:
Family lives in City:	County:

PRESENTING PROBLEM(S) (check all that apply)

- | | |
|---|--|
| <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: _____ |
|---|--|

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,
Legal Aid Society of San Mateo County,
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
 M. Stacy Hawver, Executive Director