

The Peninsula Family Advocacy Program
A Medical-Legal Partnership for Children
Lucile Packard Children's Hospital and Ravenswood Family Health Center

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)

- | | |
|---|--|
| <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 Guzmán, Fax Number: (650) 517-8973. If possible, please leave a voicemail explanation at (650) 517-8904.

IF YOUR PATIENT HAS A LEGAL EMERGENCY CALL (650) 517-8904. OTHERWISE, OUR PROGRAM WILL ATTEMPT CONTACT W/IN 2 BUSINESS DAYS OF REFERRAL.

LEGAL AID SOCIETY
 OF SAN MATEO COUNTY
 The Natalie Lanam Justice Center
 Sobrato Center for Nonprofits-Redwood Shores
 330 Twin Dolphin Drive, Suite 123
 Redwood City, CA 94065

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|---|--|

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

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Form updated May 2012