The Peninsula Family Advocacy Program

A Medical-Legal Partnership
San Mateo Medical Center Obstetrics Clinics

☐**San Mateo Medical Center Clinic** ☐ **Willow Clinic**

☐ **Fair Oaks Clinic** ☐ **Coastside Clinic**

Provider's Name:	**Patient's EDD:**
Patient's Name:	
Type of Provider:	**Family's Phone #:**
Provider Phone #:	**Other Contact #:**
Provider Pager #:	**Okay to Leave Message?: Yes No**
Consultation Date:	**Preferred Language:**

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: _____

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 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

Form updated May 2012

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- ☐ 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

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