Community Health Worker Referral

Fairfield County Health Department

Referring Clinic_____

Phone (_____) _____

Referring Staff_____

Referring Staff Email_____

Name _____ Phone _____

Date of Birth _____ ☐ Male ☐ Female

☐ Pregnant / Due Date _____ ☐ Postpartum / Delivery Date _____

Address _____ City _____ Zip _____

Email _____ Best time to be reached _____

Is the participant aware of this referral _____Yes _____ No

Insurance Status (please circle) **Uninsured** **Private Insurance** **Medicaid** **Medicare**

Provider Name _____ Policy Number _____

Please Check all the following areas you/the patient may need assistance with

- ☐ Housing
- ☐ Food
- ☐ Clothing
- ☐ Education/GED
- ☐ Car Seats
- ☐ Diapers
- ☐ Pack N Play/ Safe Sleeping
- ☐ WIC
- ☐ Utilities
- ☐ Transportation
- ☐ Dental
- ☐ Medical Referrals
- ☐ Vision
- ☐ Legal Assistance
- ☐ Smoking Cessation
- ☐ Specialty Care
- ☐ Domestic Violence
- ☐ Substance Abuse
- ☐ Translation Assistance
- ☐ Health Insurance
- ☐ Identification Assistance
- ☐ Pregnancy Assistance
- ☐ Other _____

Any additional information that may be helpful:

_____

_____

_____

Date Received _____ First Contact Made_____

Scan to: landon.spangler@fairfieldcountyohio.gov Fax To: 740-653-6626
1150 Sheridan Dr Ste. 100 Lancaster Ohio 43130
Landon Spangler Community Health Worker 740-652-7815