Logged Date/Initials: _____

consumer health coalition
raising health

CONSUMER HEALTH COALITION REFERRAL FORM

By filling out this form, I give the Consumer Health Coalition permission to contact me in regard to my healthcare needs. Please fax this form to 412-456-1096.

Name: _____

Address: _____

_____

Phone #: _____ Alternate Phone #: _____

Email Address: _____

How did you hear about us? _____

Do you live in the **city** of Pittsburgh? YES NO Which neighborhood? _____

Which county do you live in? _____

Did you serve in the military? YES NO Enrolled in VA health program? YES NO

Do you need an interpreter? YES NO Language spoken? _____

Notes on what the person/family needs help with:_____

Signature of consumer or representative: _____

For Office Use Only:

Type:
- ☐ Phone Consultation
- ☐ On-site event
- ☐ On-site at CHC
- ☐ Follow-up
- ☐ Email Query
- ☐ Mail/fax Query

Barrier:
- ☐ ACA Assistance
- ☐ MA Assistance
- ☐ CHIP Assistance
- ☐ MA Expansion
- ☐ Gave Resource Guide
- ☐ Other: _____

Date: _____**Time Spent:** _____

Notes:

Scheduled with: _____ **Date:** _____**Time:**_____ ☐ **in person** ☐ **on phone**

415 East Ohio Street | Suite 300 | Pittsburgh, PA 15212 | 412-456-1877