CareReach

BRIDGE COUNSELING REFERRAL

Phone: 828-772-4719 Fax: 828-398-2734

1) Patient Last Name: _____First Name: _____

2) Date of Birth: _____/_____/_____ 3) Gender Pronouns:_____

4) Gender Identity (please circle one below):

Male / Female / Transgender Male / Transgender Female / Queer / Decline / Other: _____

CONTACT INFORMATION*:*

Has the patient been notified that a Bridge Counselor will be contacting them? (Yes** or **No)

(Bridge Counselor unable to contact patient without consent; if answer is NO-please have patient call 828-772-4719)

1) Address: _____Apt/Suite/Lot_____

City: _____State: _____ Zip Code:_____

2) Primary Phone: _____Is this a **Landline** or **Cell?** (circle one)

Ok to leave Voicemail (circle one)? **YES** or **NO** OK to text message (circle one)? **YES** or **NO**

Secondary Phone: _____Is this a **Landline** or **Cell?** (circle one)

Ok to leave Voicemail (circle one)? **YES** or **NO** OK to text message (circle one)? **YES** or **NO**

Additional Information about the Contact information listed above *(i.e. this is friend, relative's, or agency's phone/address, best time to contact patient, are there any privacy concerns to be aware of, etc.)?*

DIAGNOSIS INFORMATION: Date and place of Hep C diagnosis: _____

Additional information regarding diagnostic, treatment, and patient needs:

_____

_____

Does the patient have a primary care provider? Does the patient have insurance?

Yes, Practice:_____ No Yes, Type: _____ No

Barriers to Hep C Education and Treatment

____ Transportation issues ____ English as second language ____ Literacy concerns

____ Current/past/suspected substance use ____ Cognitive limitations ____ Other: _____

Has Patient Received Hepatitis A/ B vaccination: Y ☐ N ☐ Twinrix: ☐ Unknown: ☐

Referred by:_____**Agency:**_____**Date**:_____

Email:_____**Phone:**_____

For questions or referral by phone please contact the Bridge Counselor by calling 828-772-4719