Colorado Health Network Medical Clinic
External Agency Referral Form

Name of Referring Agency: ________________________ Referral Date: ________________

Name and title of person referring: ____

Agency Address: ____

Agency Phone Number: __________________________ Agency Email: ______________________________

Agency Fax Number: _______________________________

Client Name: ______________________________________ Pronouns: ____________________________

Phone Number: _____________________________________ Age: _________________________________

Gender Identity:___________________________________ Ethnicity:_____________________________

Preferred Language: ____________________

Email: ____ Preferred Comm: □ Phone □ Email

Can leave a message? □Yes □No **Can ID CHN when calling?** □Yes □No

Monthly Income: ______________________

Does Client Receive? □ SSI □SSDI □Medicare □Medicaid □Private Insurance?______________________

Is Client registered with: □ ADAP □ PHIP □ Gilead Co-Pay Card □Gilead Advancing Access

Client seeks: □HIV Care □ PrEP □nPEP □ HCV Care

□ Transgender care (Living with HIV) □ Transgender Care (PrEP)

Is client currently receiving medical care? If so, where? ____

Any other relevant information for provider to know?

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Secure Email to: Gilbert.Irizarry@coloradohealthnetwork.org or Tessa.Owens@coloradohealthnetwork.org
Or fax to: 720.372.7849. To speak to a member of our team, dial: 303-962-4495.