Disclaimer: When saving this referral form, please save to new file name to retain original template.

vivanthealth

Social Work Referral Form

Member name: _____

Member ID: _____ Date of birth: _____

Authorization number, if applicable: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home phone number: _____ Cell phone number: _____

Language spoken: ☐ English ☐ Other _____

Responsible Party

First name: _____ Last name: _____

Phone number: _____

Referral criteria: ☐ Access ☐ Transition ☐ Entitlement ☐ CBO ☐ Access ☐ Other

Reason for referral: _____

_____

_____

_____

Recommendation for the criteria: _____

_____

_____

_____

Primary diagnosis: _____

Name of referrer: _____ Date of request: _____ Time: _____

Location of supportive documentation: _____

Please review the scope of service before submitting to the following email: **socialwork@vivanthealth.com.** The Social Work Department will respond within 5 business days once received.

Vivant Health | P.O. Box 15470, Sacramento, CA 95851 | (916) 228-4300