



CATAWBA VALLEY HEALTH SYSTEM

FaithHealth Catawba Referral Form

Patient/Client Name:

Referral Date:

DOB:

Race:

Physical Address & County:

Contact Number:

Emergency Contact (Name & Number):

Contact Precautions/Allergies/Other Health Concerns:

Primary Care Provider:

Primary Insurance:

Reason(s) for Referral (Check all that apply):

- Establish Primary Care Healthcare Advocacy Food Assistance
- Medications Health Insurance Other (specify):

Healthcare Advocacy

Date/Time of Appointment(s):

Address of Appointment(s):

Verbal permission for FaithHealth Catawba involvement: Yes No

Urgency: High Low

Referring Provider:

Referring Provider Telephone Number/Email:

If applicable, check all that apply for additional services/referrals from the following options:

- Social/Emotional/Spiritual Care (ex: home visitation, prayer, conversation)
- Encouragement to Seek Medical Attention Appointment Reminders
- Housing DME Help Completing Forms for Services
- Help Compiling Documentation for Services Other (specify):

Special Modifications/Arrangements (e.g. Dietary Restrictions, Physical Disabilities):

Frequency: One Time Intermittently Continuously

For medications check one of the following (attach medication list):

- Financial Assistance Education

Mental Health Concerns: Yes (please explain) No

We ask that you please submit your request 48-72 hours prior to the date of need. Please note we DO NOT provide same day services. For additional information contact: Carolyn Thompson/Faith Community Nurse at 828-485-2300 ext. 6205 or cwthompson@catawbavalley.com.



Office Use

Notes: