UT Health San Antonio
TACKLE Program

REFERRAL FORM

CLIENT INFORMATION

NAME *Last* *First* *M.I.*	MEDICAL RECORD NUMBER
HOME ADDRESS *Street* *City* *State* *Zip*	PHONE NUMBER
DATE OF BIRTH *(mm/dd/yyyy)*	DATE OF REFERRAL *(mm/dd/yyyy)*

REFERRAL INFORMATION

	Referral From		Referral To		
	Clinic Name		Clinic Name		***Point of Contact***
HIV/HCV Clinic	☐ CBWF	HIV/HCV Clinic	☐	CBWF	*Kristen Mosley*
	☐ SAAF		☐	SAAF	*Suzy LaPointe or Viola Castillo*
	☐ VAC- Harlingen		☐	VAC- Harlingen	*Ramon Torres*
	☐ VAC- McAllen		☐	VAC- McAllen	*Enery Mendoza*
SUD/MH	☐ CHCS	SUD/MH	☐	CHCS	*Veronica De Hoyos*

Reason for Referral

☐ **SUD/MH Referral**	Date *(mm/dd/yyyy)*	Scores
SAMISS		*Q1+Q2+Q3:* ______ Q4: ______ Q5: ______ *Q6:* ______ Q7: ______
PHQ-9		Score: ______
☐ **Confirmed New HIV Infection**	Date *(mm/dd/yyyy)*	Results
HIV screening test		
HIV confirmatory test		

Signature of Provider ______ Print Name ______ Date ______

My Signature to this document signifies that I have knowledge of and consent to this referral. My questions have been answered to my satisfaction. I hereby authorize the physician, hospital or clinic who attend me to disclose when requested to do so, information with respect to my present illness or medical history.

Signature of Patient ______ Print Name ______ Date ______

APPOINTMENT DETAILS

APPOINTMENT WITH	DATE *(mm/dd/yyyy)*	TIME	LOCATION

Version 2: 1/08/2019