EIS RECONNECT TO CARE REFERRAL

Attn: Sorgalim "Sol" Mendez
28 Grand Street, HTFD CT
860-296-6400 ext. 1004 ~ Cell 860-713-1520 ~ Fax 860-728-3782

Referring Agency/Address_____
Contact Person_____***Phone*** _____***ext***_____
Fax _____ ***Email*** _____
Date_____

Please circle all that apply:
(RE) connect to: Core Medical Care Case Management CADAP/CIPA

Client Name					
Client nick/ street name	**Date of Birth:**				
Address					
City/ Zip					**Is it ok to go to address? Y / N**
Home Phone Is it ok to contact? Y / N		**Cell Phone**			
Alternate Contact Is it okay to contact? Y / N	**Name**		**Relationship**		
Address					
City/ Zip					
Home Phone		**Cell Phone**			
Alternate Locations *(soup kitchens/ food pantries)*					
Race	White	Black	Hispanic	Asian	Pacific Islander
	Native Am	Other/ Specify			
HIV Status	HIV	AIDS	**Diagnosis Date**		
Substance Abuse History	**Please indicate YES OR NO and a brief comment*				
Mental Health History	**Please indicate YES OR NO and a brief comment*				
Support Systems	**Indicate where client might have meals, sleep, get support and /or hand out*				

APPOINTMENT INFORMATION	
Provider name and number	
Last kept Infectious Disease/Medical appointment	
**Next Medical Appointment*	
MCM name and Number	
****Last kept MCM appointment***	**Next MCM appointment*

Additional Notes/Comments:

Please include a current RELEASE OF INFORMATION and CONSENT AGREEMENT with the referral