HONEST
Health Center

HONEST Health Center Inc.
CLIENT REFERRAL FORM
Office: (954) 673-0270

Client Information
Client Name: _____
Name of Parent/Caregiver (if applicable): _____
Date of Birth (DOB): _____
Phone Number: _____
Client/Parent Email: _____
Physical address: _____
Sex at Birth: Male / Female
Gender identity: Male / Female / Non-Binary / Transgender
Insurance provider and member ID: _____
Emergency contact: _____

Reason for Referral
Presenting concerns and clinical observations: _____
_____
_____
_____

Treatment history and outcomes: _____
_____
_____
_____

Current medications and medical notes : _____
_____
_____
_____

Referring Provider Information
Name: _____
License #: _____
Organization & Contact Info: _____

Requested/Preferred HHC Team Member: _____