Community Healthcare Network
60 Madison Avenue 5th Fl.
New York, NY 10010

Referral Form

Outreach Manager: Keisha Fothergill (646) 634-9766, kfothergill@chnnyc.org or hhcma@chnnyc.org

Client Name:

D.O.B:

Address:

Medicaid CIN Number:

Phone Number:

Home: **Cell:** **Other:**

Language (s):

☐English ☐Spanish ☐Creole ☐Bengali ☐Cantonese/Mandarin ☐French ☐Other:

Chronic Conditions:

☐Diabetes ☐HIV/AIDS ☐Hypertension ☐Asthma ☐PTSD ☐ Depression ☐Schizophrenia
☐ COPD ☐Cardiovascular ☐Substance Use ☐Smoking/Tobacco Use ☐ Obesity ☐ Others:

Services Needed: ☐ Transgender Health Services
☐ health Justice Network
☐ Social Services

Referring Agency: **Referrers Name:**

Contact Number: **Email:**

Clients Identified Need(s)/Reason for referring: