New Jersey Department of Health

PATIENT REFERRAL

Instructions to Referring Agency:
Complete Section I. Forward two copies of the Patient Referral form. Retain a copy of the Patient Referral until a completed copy is returned to you by the Consultant Agency/Provider.
Instructions to Consultant Agency/Provider:
Complete Section II and return one copy back to the Referral Agency. Retain a copy for your records.

SECTION I - TO BE COMPLETED BY REFERRING AGENCY		
Name of Patient	Name of Referring Agency	Name of Consultant Agency/Provider
Street Address	Street Address	Street Address
City, State, Zip Code	City, State, Zip Code	City, State, Zip Code
Date of Birth	Telephone Number	Telephone Number
Reason for Referral		

Authorization is hereby given to the Consultant Agency/Provider to release their findings and recommendations to the Referring Agency.

Name of Parent or Guardian (Print)	Signature of Parent or Guardian	Date
Name of Witness (Print)	Signature of Witness	Date
Name of Health Care Provider (Print or Type)	Signature of Health Care Provider	Date

SECTION II - TO BE COMPLETED BY CONSULTANT AGENCY/PROVIDER		
Findings and Recommendations		
Name of Health Care Provider (Print or Type)	Signature of Health Care Provider	Date