community human services

PATH CLINIC REFERRAL

Please email completed referrals to referral365@chscorp.org	Date of Referral: / /

DEMOGRAPHIC INFORMATION	
Name:	**DOB:** / /
Phone number(s):	**Email(s):**

HOUSING STATUS (PLEASE CHECK ALL THAT APPLY)	YES	LOCATION
Streets/Place not meant for human habitation		
Shelter		
Doubled Up		
Housing Program		

BEHAVIORAL HEALTH CRITERA	YES	NO
Substance Use Disorder		
Mental Health Diagnosis		
Co-Occurring Disorder		

ADDITIONAL INFORMATION

REFERRAL SOURCE:	
Name:	
Agency:	
Phone number:	
Email:	

FOR PATH STAFF:	
Accepted date:	Denied Date:
	If denied, rationale:
Appointment for PATH enrollment:	
Next appointment:	