Georgia Department of Public Health
State Refugee Health Program
Physical Health & Mental Health Linkage Coordination Referral Form

Referral Source Information

Agency: ___________________________ Date: ______/______/__________

Name: ___________________________ Title: ___________________________

Phone: ________________ Fax: ________________ Email: ___________________________

Client Information

Name: ___________________________ Date of Arrival (US):______/______/__________

DOB: ______/______/_________ Gender: ☐ F ☐ M County: ___________________________

Birthplace (Country): ___________________________ Patient Medical #: ___________________________

Primary Language: ________________ ☐ Speaks some English Medicaid #: ___________________________

Address: ___________________________ CMO: ___________________________

City: ________________ Zip Code: ______________ Alien #: ___________________________

Primary Phone #: ______________ Other Phone #: ______________ Agency/Sponsor: ___________________________

Reason(s) for Physical Health Referral (Select all that apply)

☐ **Tuberculosis:** ☐ Infection ☐ Disease

☐ **Hepatitis:** ☐ B ☐ C ☐ Other ________________________

☐ **Sexually Transmitted Infections (STI)**

Please specify: ___________________________

☐ **HIV** ☐ CD4 > 200 ☐ CD4 < 200

☐ **Pregnancy**

☐ **Non-Compliance with Treatment**

☐ **Other Chronic Health Issues, specify:**

____

Reason(s) for Mental Health Referral (Please specify)

☐ **Previous history of mental health concerns?** ________________

☐ **History of psychiatric hospitalization?** ________________

☐ **History of suicide attempts?** ________________

☐ **Currently suicidal?** ________________

☐ **History of torture/trauma?** ________________

☐ **Domestic violence concerns?** ________________

☐ **Substance abuse/dependence concerns?** ________________

***Please attach the overseas psychological evaluation, if applicable.**

Overseas psychological evaluation attached? ☐ **Yes** ☐ **No**

Services(s) Requested (Select All that Apply]:

☐ **Follow-up Care**

☐ **Health Education**

☐ **Assist with Compliance Treatment Plan**

☐ **Other, specify:** ___________________________

Services(s) Requested (Select All that Apply):

☐ **Follow-up Care**

☐ **Mental Health Education**

☐ **Assist with Compliance Mental Health Treatment Plan**

☐ **Other, specify:** ___________________________

Additional Comments / Concerns Section: ___________________________

FOR OFFICE USE ONLY:

Date Referral Received: ______/______/__________ **Received by:**___________________________ **Approved: [ ] Yes [ ] No**

Email Encrypted Referrals to Joan Foderingham, Refugee Health Social Worker, Joan.Foderingham@dph.ga.gov

Important Warning: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If you are not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any disclosure, copying or distribution of this information is Strictly Prohibited. If you have received this message by error, please notify the sender immediately to arrange for return or destruction. Unauthorized redisclosure for failure to maintain confidentiality could subject you to penalties described in federal and state law.

Revised 03/15/2023