

**COMMWELL HEALTH
POSITIVE LIFE
PATIENT REFERRAL FORM**

Name _____

Address: _____

City: _____ State: _____ Zip: _____

Phone#: _____ DOB: _____

Marital Status

Married Single Separated Divorced Widowed

Insurance Status

Insurance Medicaid ADAP-please include Case # _____

Services Needed: Case Management Medical/ ID Dental
 HCV PrEP HIV/AIDS

Diagnosis Date/Location: _____

Primary Care Physician: _____

Agency Name: _____

Telephone#: _____ Fax#: _____

Case Manager: _____

Agency Name: _____

Telephone#: _____ Fax#: _____

Referred By: _____

Agency: _____

Telephone#: _____ Fax#: _____

Signature: _____ Date: _____

Clinic Contact Person:

**CommWell Health – Positive Life
3331 Easy Street
Dunn, NC 28334
Telephone #: 919-567-6194
Fax #: 910-567-5678**

Lisa McKeithan- Positive Life Director
Cheryl Bellamy: Lead Case Manager
Elizabeth Nelligan: Case Manager
Amber Johnson: Case Manager
Brittany Bradshaw: Nurse

Office Use Only: Date Referral Received: _____ Staff: _____