



San Mateo Medical Center Health Care for the Homeless Program

Fair Oaks Same Day Clinic Referral Form

Patient Name: _____

Date of referral: _____

Date of Birth: Month _____ Day _____ Year _____

Gender: _____ SSN: _____ - _____ - _____

Person making referral: _____

Referring organization: _____

Phone: _____

Preferred language: _____

Phone number: _____

Ethnicity _____ Health Insurance _____

Family Members _____ Monthly Income _____

Individual is living at the following: (please check one)

- Homeless Shelters
- Transitional Housing (i.e. hotel, rehab center, transitional shelter programs etc)
- On the Streets (i.e. car, park, abandon building)
- Temporality with friends or extend family

REASON FOR REFERRAL (Describe in one or two sentences):

If you have questions regarding referring a homeless person into the Fair Oaks Same Day Clinic please call 650-573-2966 or send an email to mkennedy@co.sanmateo,ca.us

If possible please fax a copy of the referral form to the HCH Program (650) 573-2966 or an email to mkennedy@co.sanmateo,ca.us so the HCH Program can assure that the individual received service.