Colorado Health Network Medical Clinic
External Agency Referral Form

Name of Referring Agency: _____ Referral Date: _____

Name and title of person referring: _____

Agency Address: _____

Agency Phone Number: _____ Agency Email: _____

Agency Fax Number: _____

Client Name: _____ Pronouns: _____

Phone Number: _____ Age: _____

Gender Identity:_____ Ethnicity:_____

Preferred Language: _____

Email: _____ Preferred Comm: □ Phone □ Email

Can leave a message? □Yes □No **Can ID CHN when calling?** □Yes □No

Monthly Income: _____

Does Client Receive? □ SSI □SSDI □Medicare □Medicaid □Private Insurance?_____

Is Client registered with: □ ADAP □ PHIP □ Gilead Co-Pay Card □Gilead Advancing Access

Client seeks: □HIV Care □ PrEP □PEP □ Transgender care (Living with HIV)
□ Transgender Care (PrEP)

Is client currently receiving medical care? If so, where? _____

Any other relevant information for provider to know?

_____

_____

_____

Note to Referring Staff Member: The medical clinic is only seeing clients who are living with HIV or are on or seeking PrEP. For these clients, the clinic can offer medication management, primary care, transgender transitional medical care, and lab work.

Please securely email form to Andrew.Miller@Coloradohealthnetwork.org or fax to 720.372.7849. . For more information, please call 303-962-4495.