Kedren Community Care Clinic

4211 SOUTH AVALON BOULEVARD,
STE A
LOS ANGELES, CA 90011
BUSINESS PHONE: (323) 234-0616

PRIMARY CARE REFERRAL FORM

Complete this form to refer patients to Kedren's Community Care Clinic

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ ☐M ☐F
Last, First

If patient is Minor, Parent(s) Name: _____

Medi-Cal # _____ **OR** Social Security Number: _____

Patient's Home Address: _____

Phone Number: _____ Preferred Language:_____

Medical Diagnosis(es) (if known):_____

Psychiatric Diagnosis(es) (if known): _____

REFERRING STAFF INFORMATION

Name of Mental Health Program: _____

Print Name and Title of Referring Staff: _____

Signature: _____Date: _____ Time: _____

Contact EXT: _____ Fax Number:_____

*******Dear MH Staff if an appointment is made on the phone PLEASE COMPLETE this section:**

Date and Time of Patient's Appointment:_____
Appointment made by: (Name of Primary Care Clinic Staff)
_____

PLEASE COMPLETE ALL THAT APPLY

1. **Insurance Type (Please check):** MEDI–CAL ☐ COVERED CA ☐ NONE ☐ OTHER ☐

(If other is checked please provide name and phone number)

_____

2. **Primary Care Provider (PCP)** (Check One):
   ☐No PCP ☐I have PCP but want to switch to Kedren

Name of current Primary Care Provider and Phone Number (if known):

_____

Reason for requesting change of PCP:

_____

FAX TO : (323) 515-7017 ATTN: KEDREN COMMUNITY CARE CLINIC

RESET BUTTON