Bridges to Wellness Referral

Scan to: coordinator@accesstusc.org
OR Fax to: 330-343-4883

Referring Agency: ___________________________ Phone # ____________________________

Referring Staff Member: ___________________________________ Date: _________________

Staff Member E-mail: ____________________________________

Patient Name: ____ **Phone #** ____________________________

Address: ___________________________ **City**: _____________ **Zip**: ____________ **County**: ___________________

Date of Birth: ______________________

Medicaid Insurance Status (please circle): Buckeye CareSource UHC Molina Other: ______________________

Pilot Population (Circle One): Pregnant Woman Opiate Addiction (Recent Addiction)

Please check off the following areas the patient may need assistance with:

- Health Insurance/Medicaid Application
- Housing
- Food
- Clothing
- Utilities
- Access to Medication
- Taking Medication Correctly
- Frequent ER Visits
- Smoking Cessation
- Immunization
- Medical
- Transportation
- Dental
- Legal
- Specialty Care
- Domestic Violence
- Pregnancy Assistance
- Other: ________________________________

Any additional information regarding patient that may be helpful:

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Office Use Only
Date Received: ____/_____/____ **Assigned To:** _______________ **1st Contact:** _______________
2nd Contact: _______________