COMMUNITY WELLNESS PROGRAM
Intake & Referral Form

Date: _____

Staff Completing Form: _____

Staff Phone Number: _____

HOPE SF Site: _____

PLEASE EMAIL TO:
cwp.referrals@sfdph.org

Is the referral for a minor? ☐ **Yes** If **yes**, please fill out sections below		☐ **No**	
Caregiver's Name:		**Phone #:**	
Caregiver's Primary Language:		**Name of minor:**	

Resident Demographics			
Existing CWP Client?	☐ Yes ☑ No (If **no**, complete section)	**Updated Information?**	☐ Yes ☑ No (go to Resident Consent)
Name:		**Date of Birth:**	
Preferred Name:		**Home / Cell Phone:**	
Address:		**Email:**	
City:		**Preferred Contact Method:**	
Zip Code:		**Language Preference:**	

Gender Identity:		**Marital Status:**	
Race / Ethnicity:		**Pronouns:**	
Sexual Orientation:		**Sex assigned at birth:**	

RESIDENT CONSENT TO RELEASE INFORMATION

I (a resident/client of Hope SF) authorize the exchange of information between my referring agency and the HOPE SF Community Wellness Program for the purposes of completing this referral. I authorize the sharing of contact information (telephone number / email / home address) and reason for referral by the referring agency for the purpose of accessing resources and services available.

Resident Signature (if Verbal Consent is given, please check box here): ☐ _____	**Date :**	
	Time:	

REASON FOR REFERRAL - Select All that Apply

Health and Wellness Activities and Support	☐	
Nursing	☐	
Psychiatric Nurse Practitioner	☐	
Health Navigator	☐	
Therapist / Counselor	☐	
Other	☐	