PART OF THE SHEPPARD PRATT HEALTH SYSTEM:

Sheppard Pratt HEALTH SYSTEM | Over 100 Years of Service Family Services, Inc. | Mosaic COMMUNITY SERVICES | WAY STATION

# THE LANDING REFERRAL FORM

REFERRAL DATE: _____

| **POTENTIAL MEMBER INFORMATION** | **PARENT/GUARDIAN INFORMATION** |
|---|---|
| Name: _____ | Name: _____ |
| Address: _____ | Relationship: _____ |
| _____ | Cell Phone #: _____ |
| Youth contact #: _____ | Home #: _____ |
| DOB: _____ | Alternate #: _____ |
| Type of Health Insurance: _____ | Best time to call: _____ |

**REFERRAL SOURCE:**

Name: _____ Agency: _____

Phone: _____ Email: _____

Will this agency remain involved with this client? YES NO

**REASON FOR REFERRAL/ SUBSTANCE ISSUE:**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**FOR STAFF USE ONLY**

Date Received: _____ Received By: _____

First Contact: _____ Completed? YES NO Activated? YES NO

Placed on Waiting List (Date): _____

**Please fax or email completed copy to**
**The Landing Care Coordinator, Henok Solomon at:**
**(301) 461-3477 or LandingReferrals@fs-inc.org**