Native American Connections

Referral Intake Form

Date:	Referring Agency:	Case Manager Name:	Case Manager Phone:
Case Manager E-mail:	Mother's Maiden Name:	AHCCCS #:	Primary Care Physician:
Preferred Hospital:	Other Insurance Number:	Court Appointed Guardian?	If Yes, List Guardian Name
		☐ Yes ☐ No	

Health Delivery Modality:

☐ **In-person (preferred)**

☐ **Telehealth** (Zoom- must have a smart phone or computer with a camera and internet service.)

☐ **Verbal Consent** (if unable to complete in person)**:**

☐ **Telephonic-** phone only, if in-person and Zoom aren't an option, please describe why below.

First Name:	Last Name:	Initial:	Preferred Name:	Date of Birth:
Social Security #:	Gender: Choose one	Gender Identity (optional): Choose one	Sexual Orientation (optional) Choose one	Race: Choose one
Tribal Affiliation:	Ethnicity: Choose one	Primary Language:	Preferred Language:	Preferred Pronoun:
Client Address:	City:	State:	Zip Code:	Preferred Contact:
Address Status: Choose one	Cell Phone:	Work Phone:	Home Phone:	E-mail:
Allow Text Message: ☐ Yes	Contact Status: Choose one	Language Assistance: Choose one	Marital Status: Choose one	Military Status: Choose one

Have you received the COVID-19 vaccine? ☐ **Yes** ☐ **No** **Do you have a CIB or a tribal card?** ☐ **Yes** ☐ **No**

How did you hear about NAC?	What services are you interested in receiving?	Program Indicator:
Choose one	Choose one	Choose one

Are you currently experiencing homelessness? ☐ No ☐ Yes

Are you registered as a sex offender? ☐ No ☐ Yes

Are you currently in NAC housing? ☐ No ☐ Yes

Are there any needs/preferences you would like to share with us (spiritual, racial/ethnic, disability, gender identity, sexual orientation, nationality, tribal, two-spirit, preferred pronouns, relationship status, etc.)?

IV drug use? ☐ No ☐ Yes	Tobacco use? ☐ No ☐ Yes	Fentanyl use? ☐ No ☐ Yes
Substance name:	Date of last use:	Amount used:
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Do you have current legal involvement? ☐ No ☐ Yes If "yes", please describe:

Any current psychiatric/ behavioral health services? ☐ No ☐ Yes If "yes", please provide contact info:

Are you currently receiving MAT Services? (Medication-Assisted Treatment) ☐ No ☐ Yes If "yes", which treatment/clinic?

Emergency Contact Information:

Name:	Relationship to client:	Address:	Phone:

Client Signature: **Date:**