



99 West 26th Street
 Holland, MI 49423
 Phone: 616-392-3610
 Fax: 616-392-3632

Holland Free Health Clinic: Referral for Services

Client Name: _____ Date of Birth _____

Address: _____

Phone Number: _____ Email Address: _____

Primary Language: English _____ Spanish _____ Other _____

Insurance? Y/N Private _____ Medicaid _____ Medicare _____ Medicare Pt. D Not sure _____

Mental Health Coverage? Y/N Other _____

Yearly Income: _____ #Persons in Household _____

Presenting problem/Assistance needed:

Programs patient is being referred for, check all that apply:

Dental Care	Vision Care	Chiropractic Care
Mental Health Counseling	Diabetic Education/Resources	Medication Assistance
Hearing Aid Assistance	Pamper & Prayer (Foot Care)	

I affirm that the above named patient has granted me permission to share this information in order to obtain services through the Holland Free Health Clinic (HFHC). The patient has agreed to accept a phone call from the HFHC to arrange an enrollment appointment. The patient has also been encouraged to call the clinic Monday - Thursday, 9am-4pm at (616) 392-3610 to schedule an enrollment appointment.

Referring Person: _____ Title: _____

Business/organization/practice name: _____

Email _____

Phone: _____ Fax: _____

*We are not able to accept referrals for those in crisis. We do not have primary care doctors.