

Project Freedom Referral Form

Date _____

Referring Organization: _____

Organization Address: _____

City, State, ZIP: _____

Referral contact: _____

Telephone: _____ Fax: _____

Email: _____

Client Name: _____

Client Address: _____

Contact Person: _____

Relationship: _____ Email _____

Phone: _____

Type of disability: _____ Weight _____

Has referring organization determined financial need? Yes No

Does the patient have medical insurance to cover a patient lift? Yes
No

Has the referring organization made candidate aware of Project Freedom? Yes No

How long has referring organization worked with the patient? _____

Fax completed form to (734) 264-0726 or (810) 632-0597

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