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