GRACE BESIDE YOU

HEALTHCARE NAVIGATION & PATIENT ADVOCACY

PROFESSIONAL REFERRAL FORM

1. CLIENT INFORMATION

Client full name: _____ Date of birth: _____

Preferred phone: _____ Email: _____

Preferred contact method: ☐ Phone ☐ Email Best time to contact: _____

City / State: _____ ZIP code: _____

Caregiver / family contact (if applicable):
_____

Relationship: _____ Phone / Email:
_____

2. REASON FOR REFERRAL

What type of healthcare navigation support is needed? (Check all that apply.)
□ Healthcare system navigation and coordination □ Appointment scheduling and care coordination □ Specialist referrals and insurance authorizations □ Insurance or access-to-care barriers □ Medical records and healthcare communication □ Complex or ongoing healthcare needs □ Caregiver and family support □ Other:

Briefly describe the support requested:

_____

_____

_____

3. REFERRING PROFESSIONAL / ORGANIZATION

Referring professional: _____ Title / role: _____

Practice / organization: _____ Specialty / department: _____

Phone:
_____ Email: _____

4. CLIENT CONSENT TO BE CONTACTED

Please confirm the client has agreed to be contacted by Grace Beside You about non-clinical navigation services. Do not send this form unless you have appropriate permission to share the information included.

☐ Client has agreed to be contacted. ☐ Referrer will help client connect directly.

Client / authorized representative name (if obtained):
_____

Signature (if required by your process):
_____ Date:
_____

5. SUBMISSION & IMPORTANT INFORMATION

Scope: Grace Beside You provides non-clinical healthcare navigation, patient advocacy, care coordination, and community-resource navigation. It does not provide diagnosis, prescribing, medical treatment, or emergency services, and does not replace the client's healthcare providers. A referral does not guarantee acceptance, availability, or insurance covrage