

TODAY'S DATE:

Patient Details					
Name: Goes by: MRN:		Date of Birth:		Address/location:	
Phone:		Email:		Preferred Language:	
Referring agency/person:		Referring agency/person ph #:		Reason for request:	
Description of client:					
Health Insurance Carrier/Company Name: _____ Have you received health services at VHHP? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> I Don't Know Do you have a PCP? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> I Don't Know PCP name, clinic name, & loc: _____					
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	Race (Check All That Apply): <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White	Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I Don't Know	Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female (MTF) <input type="checkbox"/> Transgender Female to Male (FTM) <input type="checkbox"/> Non-Binary	Partner Gender(s): <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female (MTF) <input type="checkbox"/> Transgender Female to Male (FTM) <input type="checkbox"/> Non-Binary

Race code list source: [Appendix E Race Code List \(cdc.gov\)](https://www.cdc.gov/racecode/)