



BRIDGE COUNSELING REFERRAL

Attention: Michelle Goyeau

Phone: 828-772-4719 Fax: 828-398-2734

Patient Name: _____ DOB: _____

Address: _____

Gender Identity: M__F__ Other: _____ Veteran: ____ Y ____ N ____ Unknown

Home Phone: _____ Ok to lv msg? Y__ N__

Cell Phone: _____ OK to lv msg? Y__ N__

Other contact information (if applicable): _____

Diagnosis Information

Date and place of Hep C diagnosis: _____

Has the patient been notified that a Bridge Counselor will be contacting them? Yes _____ No _____

Additional information regarding diagnostic, treatment and patient needs:

Medical Care Information

Does the patient have a primary care provider?

____ Yes, Practice: _____

____ No

Does the patient have insurance?

____ Yes Type? _____

____ No

Barriers to Hep C Education and Treatment

____ Transportation issues

____ English as second language

____ Literacy concerns

____ Current/past/suspected substance use

____ Cognitive limitations

____ Other: _____

Has Patient Received Hepatitis A/ B vaccination: Y ____ N ____ Twinrix: ____ Unknown: ____

Referred by: _____ Agency: _____ Date: _____

Email: _____ Phone: _____

For questions or referral by phone, please contact Michelle Goyeau at 828-772-4719.