



SUPPORT SERVICES
PATIENT & SELF REFERRAL FORM

PLEASE NOTE: If a patient is in imminent danger of harming themselves or others or is at risk of abuse or neglect, please call 911, in addition to completing this form.

Date: _____

Name: _____ Phone: _____

Reason for Referral:

Please include all information you think would be helpful, such as your diagnosis, age, type of medical care you are receiving, your medical provider, type of insurance coverage, etc.

A Social Worker will contact you during regular office hours, within 48 hours of this referral, unless otherwise noted. Social workers can evaluate and provide counseling for: depression, anxiety and adjustment disorders. Social workers can also assist patients in obtaining insurance, financial assistance, home care and other social needs. If you are making a referral on behalf of someone else, we will contact the person you are referring directly. We may not disclose information about a Cancer Center of Santa Barbara patient without their permission, according to HIPAA Regulations (see below).

Please fax or email this form to the Support Services Department:

(805) 569-7715 fax
SupportServices@ccsb.org

HIPAA REGULATIONS:

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose patients' individually identifiable health information except as provided in our Notice of Privacy Practices without their authorization.