FLAGLER COUNTY FREE CLINIC

REFERRAL TO IMPOWER MENTAL HEALTH TELEHEALTH SERVICES

www.impowerfl.org

Patient's Name_____DOB:_____

Phone:_____

Medical History/Diagnosis:_____

_____

_____

_____

Print Referring Practitioner's Name:_____

Practitioner's Signature:_____

IMPOWER

Follow up:

Date:_____

Patient was seen on:_____By:_____

Appointment was made on:_____To see:_____

Miscellaneous:_____

_____

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