



ALTRUSA HOUSE  
REFERRAL FORM  
2002 NW 36th Avenue  
Gainesville, Florida 32605  
(352) 377-7708  
FAX (352) 337-9622  
LJohnson@fl.easterseals.com

DATE: \_\_\_\_\_

**CLIENT INFO:**

Client Name: \_\_\_\_\_  
(Last) (First)

Client DOB: \_\_\_\_\_

Sex: (circle one) M F Referral Reason/Diagnosis \_\_\_\_\_

Veteran Status: (circle one)

Active Military      Veteran      Family Member (active or veteran)      None

**GUARDIAN/CAREGIVER INFO:**

Name: \_\_\_\_\_  
(Last) (First)

Address: \_\_\_\_\_  
(Street address) (City, State, Zip)

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Email: \_\_\_\_\_

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Type of Insurance \_\_\_\_\_

Please attach authorization documentation if required and available.