Call (517) 899-2425 to Schedule a Ride

PHYSICIAN REFERRAL FORM

I, Dr. _____, recommend that_____,
(Print Physician's Name) (Print Child's Name)

Age: _____, receive transportation assistance from **The Davies Project**.
(child's date of birth)

I understand that only children with specialty needs qualify for this service.

This child will need help with transportation to the following types of appointments:

☐ Behavioral ☐ Cardiology ☐ Dental ☐ Endocrinology
☐ Eye Care ☐ Gastroenterology ☐ Hematology ☐ Nephrology
☐ Neurology ☐ Occupational ☐ Pre-Surgery ☐ Primary Care
☐ Pulmonology ☐ Rheumatology ☐ Speech ☐ Surgical Consultation
☐ Other: (please note type) _____

Please give **The Davies Project** an idea of the time period (with dates) during which this child can use help:
_____

PARENTAL UNDERSTANDING

The Davies Project will assist with transportation needs in the best manner they see fit. By signing this agreement, you understand that every possible measure to provide help with transportation will be made for this child's appointments by **The Davies Project**. If transportation cannot be found, ample notice will be provided by **The Davies Project** to the family. There will be a six-week window in place for re-evaluation of transportation needs if **The Davies Project** experiences problems while driving this family.

Parent: _____ Dated: _____
(Signature)

Parent: _____
(Print Name)

Physician: _____ Dated: _____
(Signature)