Please complete and email to nancy@thedaviesproject.org or fax to 517-246-4944
or mail to The Davies Project, 230 Bingham St., Suite 100, Lansing, MI 48912
Call 517-899-2425 to schedule a ride.

CLINIC REFERRAL FORM

I, . _____, recommend that _____,
(Print Physician's or other Qualified Professional's Name) (Print Patient's Name)
receive transportation assistance from **The Davies Project** due to his/her diagnosis of
_____.
(Print Patient's Qualifying Diagnosis)

I understand that only children with serious health conditions qualify for this service. Diagnoses that qualify for The Davies Project include, but **are not limited to** mental health diagnoses, autism, developmental disorders, hematology/oncology, diabetes, epilepsy, and many more.

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

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

_____

PATIENT 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 patient's appointments by **The Davies Project**. If transportation cannot be found, ample notice will be provided by **The Davies Project** to the patient. There will be a six-week window in place for re-evaluation of transportation needs if **The Davies Project** experiences problems while driving this patient.

Patient: _____ Date: _____
(Signature)

Clinic staff: _____ Date: _____
(Signature)