TRANSITIONAL FOOD & SHELTER, INC.

PO Box 4471
Paso Robles, CA 93447
(805) 468-4113
www.nowheretogo.com

Verification of Medical Need - Physician's Referral

Fax completed form to 805.221.6925

PHYSICIAN: Please note that the funds which TFS has for housing the medically-fragile homeless of SLO County are limited and carefully budgeted. These funds are for housing those who cannot be managed in a shelter setting and are used predominantly for motel rooms for limited time periods. Our program does NOT provide food, transportation or caregiver assistance within our shelter location. Submission of your request does not guarantee acceptance.

Date submitted: _____

Patient's name (Print Clearly): _____

Age:_____ **Sex** _____

Is this person at medical risk if he or she cannot be sheltered for one or more nights? Yes_____ **No**_____

Please state the medical condition which places this person at risk:

_____

_____

_____

Please state the reason why this person *could not* be adequately sheltered at an overnight shelter in the county such as Maxine Lewis, ECHO, or other). Alternatively, please state why staying at a TFS-funded shelter during the day is a requirement:

_____

_____

_____

Please state the day, date and time the patient needs to be admitted:

Day_____ **Date**_____ **Time**_____

Please state the minimum number of days that you judge the person would have to remain in the residence that TFS provides funds for: Number of days: _____

Will the person need on-site care while in the TFS housing? (Yes_____ **No**_____**)**

If so, who will provide this care? _____

Your Printed Name_____ **Date:** _____

Your Signature:_____ **Phone:** _____

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