



Patient Referral

By signing, I certify that the patient below is in need of specialty care.

Patient Name _____
Home Phone _____ Cell Phone _____
Best Number and time to call _____
Specialty Care Needed _____

Physician Signature _____

Group Name: _____

Address _____

Phone: _____ Fax: _____

Project Access will **NOT** contact patients by phone. Please call Project Access to set up an appointment to complete the appropriate paperwork. Thank You.

PHONE: (319) 892-6083

Please sign and Fax to:

(319) 892-6098

Or Mail to:

**Linn County Project Access
501 13th St N.W.
Cedar Rapids, IA 52405**

Program Requirements:

***Ages 19 – 64 *No health insurance, Medicaid/Title 19 *Meets income guidelines *Linn County resident for 90 Days**