

# Dignity Health TBI Program

**Traumatic Brain Injury Navigator Referral**  
**TBI Navigator phone: 530-226-3099**

Date of referral: \_\_\_\_\_

Referred by: \_\_\_\_\_

Phone: \_\_\_\_\_

Person referred: \_\_\_\_\_

Phone: \_\_\_\_\_

Contact person (if different than above):

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

## What resources are you seeking?

- |                                          |                                        |                                              |
|------------------------------------------|----------------------------------------|----------------------------------------------|
| <input type="checkbox"/> County Services | <input type="checkbox"/> Healthcare    | <input type="checkbox"/> Housing             |
| <input type="checkbox"/> Mental Health   | <input type="checkbox"/> Legal         | <input type="checkbox"/> Department of Rehab |
| <input type="checkbox"/> Respite         | <input type="checkbox"/> Substance Use | <input type="checkbox"/> SSA                 |
| <input type="checkbox"/> Substance Use   | <input type="checkbox"/> Support Group |                                              |
| <input type="checkbox"/> Transportation  | <input type="checkbox"/> VA            |                                              |
| <input type="checkbox"/> Other: _____    |                                        |                                              |

*You can fax this form to 530-223-0658*