

**Grand Ronde Tribal Housing Authority
Minor Medical Adaptation Grant**

Physician Referral Form

To be completed by the client's primary Physician.

Date: _____

Physician's Name: _____

Address: _____ Phone: _____

Client: _____

Client's condition: _____

What is the approximate length of the client's condition? _____.

Adaptation Requested: _____

Explain how the required adaptation will benefit the client's condition. _____

Is the adaptation _____ A. Absolutely necessary to improve the client's condition (s); or
_____ B. A convenience to improve the client's comfort; or
_____ C. Unsupported medically.

Comments: _____

Physicians Signature: _____.