

# Submitting a Referral

1. Go to [healthhubreg.com](http://healthhubreg.com) and click “View Available Health and Wellness Services”.



## Welcome

Community members can use this system to access local services and programs. Community providers not registered with this system can also use the Request-a-service button below for your patient/client.

Certain services are only available on certain days and some require an appointment. Please view the service details for more information.

- Request a Service or Check-in Now >
- View Available Health and Wellness Services >
- Registered Provider Login >

Need Help? Call 301-475-4330 >

2. Select the service you would like to refer your patient/client to from the list of available health and wellness services.



## Available Health And Wellness Services

- Social Wellness Assessment >
- SMCHD Health Clinic At Margaret Brent Middle School Based Health Center >
- SMCHD Health Clinic At Spring Ridge Middle School Health Center >
- Psychiatric Nurse Practitioner @ Health Hub (Evaluation And Med Management) >
- Business Or Employment Workshop >
- Lead Program >
- Youth Mentoring - Stella's Girls >
- Medicaid Insurance Benefit Information >
- Emergency Dental >
- Lab Services >
- Williams, McClernan, & Stack Expungement Clinic At The Health Hub >
- Asthma Program Home Visit >

3. Select "Refer A Person to this Service".



### Social Wellness Assessment

Life situations - such as food access, transportation, and housing - can affect health. This assessment helps identify what community resources could help you.

CHECK-IN OR REQUEST A SERVICE


REFER A PERSON TO THIS SERVICE


< BACK TO SERVICE LIST


4. Select "Refer by Name & Date of Birth".



### Referred Person Info

 Refer by Name & Date of Birth >

 Refer by Registration ID >

 Need Help? Call [301-475-4330](tel:301-475-4330) >

5. Submit your patient/client's referral by providing their name and contact information.

Login into Portal

### Name And Date Of Birth

First Name (required)

Middle Name

Last Name (required)

Suffix

Date of Birth (required)

MM/DD/YY

Patient Email

Patient Phone

SUBMIT