Referral Form

Date received in office: _____

Type of Service Requested:

☐ Patient Navigation / Advocacy ☐ Outpatient Therapy ☐ Psychological Evaluation ☐ Other_____

(AGENCY USE ONLY)
☐ Provider referral due to Imminent Risk Date Services Started due to Imminent Risk

Contact Information:

Individual Requesting Service: Relation to Client:

Name (person completing form) Agency:

Address:

Phone Number: Ext: Signature of person completing form: _____

Client currently receiving mental health services? ☐ Yes ☐ No If yes, list here:

Demographics of Client

First: MI Last: Gender: ☐ M ☐ F

DOB: SSN: Insurance ID # Race: (optional)

Client's Current Residence

Street:

City: NC Zip: Phone:

Primary Mental Health Diagnosis (if any)

Presenting Problem

Please list symptoms or issues that the client is currently experiencing.

Issues related to referral:
Other issues:

(AGENCY USE ONLY)
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Ok to leave phone message? ☐ Yes ☐ No Ok to mail correspondence? ☐ Yes ☐ No

*** It is highly recommended to attach the client's most recent evaluation if they have one.**