KELLIN

Referral Form

☐ **Kellin, PLLC Client** ☐ **Kellin Foundation Client**

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 MH/SA 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:

Client's Legal Guardian Information:

Name: Relation to Client:

Address: City: NC Zip:

Phone Number:

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:

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