



## 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 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.**