**Referral Form Completed by:**

**Date:**

**Clinician Assigned:**

730 Roanoke Ave, Roanoke Rapids, NC 27870 • Phone: 252-514-1560 • Fax: 252-514-1560



# Consumer information

Referral/Screening Form

# Email Address:

**Client Name**: **Date of Birth**:

Social Security #:

Address: Telephone #: County:

Type of Insurance: Insurance # MRN#: DSS Case Manager (If Applicable): Phone Number: Current School (If Applicable): Grade level (If Applicable):

# Family/Emergency Contact Information

Mother’s Name: Home Phone: Work Phone: Address:

Father’s Name: Home Phone: Work Phone: Address:

# Referral information

**Have you ever been hospitalized? ** no yes (If yes, when, where, and why)

# Have you ever received Mental Health Treatment or Developmental Disability Treatment?  no yes

**Diagnosis** (if available)**:**

**Court Involvement: ** no yes (Provide Assigned Court Counselor/ Probation Officer Information) Name Phone Number

# Requested/Recommended Services:

|  |  |  |
| --- | --- | --- |
| Diagnostic Assessment | SA Outpatient Therapy | Child Respite |
| Individual Support | Outpatient Therapy |  |
| Peer Support |  |  |

 Adult Care/ Respite