5135 Morganton Road, Ste. 104
Fayetteville, NC 28314

(910) 644-0307

(910) 222-3086

Mental Health Services Referral Form

Thank you for your referral. Our agency will contact you to confirm that the referral has been received. Please discuss the nature and intent of this referral with your client. We will contact the client to schedule an appointment.

Referral Information

Referral Date: ____________________ Referral Contact Phone: _____________________ Referral Fax: ____________________

Referral Source *(Name and Agency)* ____

Referral Address: ____

Client Information

Client Name: ____ Date of Birth: ___________________ Gender: ____________

Ethnicity: _______________________________ SS# __________________________ Insurance ___________________________

Residing with *(name and relationship)*: ____

Address: ____

Contact Home Phone: __________________________________ Contact Alternate Phone: ______________________________

Other Important Contact Information *(e.g., biological family)*: ____

Other Important Phone Numbers: ____

Medical Information

Presenting Concerns/Comments (attach additional sheets as necessary):

____

____

Diagnosis *(if known)*: ____

Referral Services Requested *(check all that apply)*:

- ☐ Individual Therapy
- ☐ Family Therapy
- ☐ Chemical Dependency Evaluation
- ☐ Family Support Work
- ☐ Supervised Visitation
- ☐ Parent Education
- ☐ Mental Status Exam
- ☐ Chemical Dependency Services
- ☐ Psychological Evaluation
- ☐ Pre---Treatment Assessment
- ☐ Parenting/Bonding Assessment

Location of Services Requested:

☐ In Office ☐ Teletherapy ☐ Other Location: ____

"We strive to improve the quality of life for individuals and families by helping them find acceptance, guidance, and hope while providing the best community service possible."