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Referral/Request for Service Form
(Please fax completed form to 910-835-0932)

Date:

Referral Source: ☐Physician ☐Agency (Name) ☐Person(s) ☐Self

Contact Name: Phone Number:

Patient Name:

Address:

Date of Birth: Social Security Number:

Sex: ☐Male ☐Female Race: Preferred Language:

Phone Number: Mobile:

Parent/Guardian Name (if referral is for a child):

Insurance Company:

☐NC Health Choice ☐ NC Medicaid ☐Medicare Part B ☐Carolina Access ☐Beacon

☐Tri Care ☐ Med Cost ☐Carolina Complete Health Network ☐AmeriHealth Caritas

☐MHN/Health Net Federal Services ☐Blue Cross/Blue Shield ☐Magellan ☐Self-Pay

☐Humana ☐Cigna ☐Aetna ☐Wellcare ☐MedTrans ☐ Logisticare ☐OneCall ☐Other:

Subscriber Name (if not patient.):

Policy/Member ID #:

Homeless: ☐Yes ☐No

Substance Abuse: ☐Yes ☐No

Discharged from Hospital: ☐Yes(Name): ☐No

Reason for Referral (check all that apply):

☐Child Care ☐ Physical Exam ☐Primary Care Provider(PCP) ☐Medication Management ☐Housing

☐Clinical Assessment/Evaluation ☐Substance Abuse Screening ☐SAIOP ☐SACOT

☐Urine Analysis (Drug Screening) ☐Family/Marital Therapy ☐Transportation

☐Individual Therapy ☐Depression ☐Anxiety ☐Stress ☐PTSD ☐AD/HD ☐DWI Assessments

☐Other:

Currently on Medication: ☐Yes (Please list on Back) ☐No

Is Patient aware of this referral: ☐Yes ☐No