Service Referral Form

Date of Referral_____ Person Providing Referral: _____

Referral Contact Telephone #: _____ Office/Mobile/Cell _____

This referral is: ☐URGENT (NEED SERVICES WITHIN 24 HOURS)

☐EMERGENT (NEED SERVICES WITHIN 48 HOURS)

☐ROUTINE (NEED SERVICES WITHIN THE NEXT 7-10 DAYS)

This referral is: ☐Voluntary ☐Involuntary

About Person Being Referred:

Name:_____ _____ Age: _____ Sex:_____ Date of Birth____/____/__

SSN: ____-____-____ Address: _____

Legal Guardian:_____ _____ Telephone#_____

Primary Care Provider (Primary Doctor): _____

Primary Insurance #: _____ Secondary Insurance #: _____

Requested Service Location:

☐ Gaston County

☐ Lincoln County

☐ Cleveland County

Primary reason(s) for seeking services (check all that apply):

☐Addictive behaviors	☐Anger management	☐Antisocial behavior
☐Anxiety	☐Conflict Resolution Issues	☐Court Involvement
☐Cyber addiction	☐Depression	☐Eating disorder
☐Elevated mood	☐Family Issues	☐Fatigue
☐Fear/phobias	☐Grief/Loss	☐Impulsivity
☐Irritability	☐Issues with authority	☐Judgment errors
☐Loneliness	☐Mood shifts	☐Panic attacks
☐Sexual concerns/dysfunction	☐Suicidal thoughts	☐Other mental health concerns
☐Financial Wellness issues	☐Motivation issues	☐Employment issues
☐Physical Wellness issues	☐Social Wellness issues	☐Spiritual Wellness issues
☐Sexual concerns/dysfunction	☐Relationship issues	☐Other issues (Please explain):

_____

_____

Household Composition:

Name: _____

Age: _____ DOB: _____ SSN: _____

Relationship to HH: _____

Name: _____

Age: _____ DOB: _____ SSN: _____

Relationship to HH: _____

Name: _____

Age: _____ DOB: _____ SSN: _____

Relationship to HH: _____

Name: _____

Age: _____ DOB: _____ SSN: _____

Relationship to HH: _____

Name: _____

Age: _____ DOB: _____ SSN: _____

Relationship to HH: _____

Name: _____

Age: _____ DOB: _____ SSN: _____

Relationship to HH: _____