**Referral Form**

**Please complete and return to** [**referrals@pchnc.com**](mailto:referrals@pchnc.com) **or fax to (704) 487-4005**

**Date of Referral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| Name (and agency, if applicable) of Person Submitting Referral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Referring Party Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Referring Party Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  OR, indicate Self Referral |

**Information on the Individual Being Referred:**

|  |  |
| --- | --- |
| Name of Client You Are Referring: | |
| Client Date of Birth: | Gender: |
| Name of Legal Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Client Alpha ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Client Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address of Legal Guardian/Client: | |
| Telephone Number of Legal Guardian/Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email Address of Legal Guardian/Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Primary Insurance: | Primary Insurance ID Number |
| Secondary Insurance: | Secondary Insurance ID Number |
| What type of assessment appointment is requested?  Behavioral Health  DWI/DWLR  Substance Use  Sex Offender Evaluation  Anger Assessment  Sex Offender Risk Assessment  Threat Assessment  Domestic Violence Intervention Program Evaluation  Other (describe):  \*All intakes must begin with a Comprehensive Clinical Assessment or a Domestic Violence Intervention Program Intake | |
| Reason for Referral (brief description): | |

**Location Preference: Rutherfordton\_\_\_ Shelby\_\_\_**

**Clinician Preference:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Office Use Only:**

SS Ins Verif. EHR Ref Email

Emergent (must be completed within 24 hours of receipt of referral

Urgent (must be completed within 72 hours of receipt of referral)

Routine

**If not accepted, referrals were offered to the following agencies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Appointment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Appointment Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Assigned Clinician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**