**Referral Form**

**Please complete and return to** **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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**