



(704) 865-3525 P ▪ (704) 865-3520 F ▪ www.supportinc.org
 Gaston ▪ Lincoln ▪ Cleveland ▪ Catawba

New Client Referral Form

Please fax this form to 704-865-3520

Date of referral:	
Referring agency and person:	
Referral phone and fax number:	
Referral address:	
Referral NPI number: (for Primary Care Providers)	
Referral Taxonomy Code: (for Primary Care Providers)	
CLIENT INFORMATION	
Full name:	
DOB:	
Sex:	
Social security number:	
Full address:	
All current phone numbers:	
Guardian name:	

INSURANCE INFORMATION

Insurance type:

Member/Recipient ID#:

Policy holder name and relationship
with client:**PRESENTING PROBLEM & NEEDS**Presenting problem and services
needed:*Please chose all services requested.*

- Medication Management Only
- Outpatient Therapy
- Intensive In-Home
- Day Treatment
- Therapeutic Foster Care
- Family Centered Treatment (FCT)
- High Fidelity Wraparound
- To be determined by clinical
evaluation

*Please detail the nature of the client's presenting problem and behavioral health
needs.*

Previous diagnoses:

Previous mental health providers:

PSYCHIATRIC INFORMATION

Known allergies:

Current psychiatric medications:

Prescribing physician (psychiatric
meds only):

Clinic name:

OTHER INFORMATIONIs the client involved with social
services or the juvenile court system?

Last school attended and grade:

Primary care physician and clinic
name: