

 **(704) 865-3525 P ▪ (704) 865-3520 F ▪ www.supportinc.org**

Gaston ▪ Lincoln ▪ Cleveland ▪ Iredell

**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)[ ]  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 INFORMATION** |
| Is the client involved with social services or the juvenile court system? |  |
| Last school attended and grade: |  |
| Primary care physician and clinic name: |  |