



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

USING OUR WEBSITE IS THE PREFERRED REFERRAL METHOD
Click on the Make a Referral tab and use the Appointment Form

New Client Referral Form

Please fax this form to 704-865-3520

If you have any questions, please email us at referrals@supportinc.org or call us at 704-865-3525, ext 2.

Date of Referral:	
Referring Agency and Person:	
Referral Phone and Fax number:	
Referral Address:	
CLIENT INFORMATION	
Full Name:	
Date of Birth:	
Sex/Race:	
Social Security Number:	
Full Address:	
All Current Phone Numbers:	
Parent/Guardian First and Last Name and Email Address (this is very important to be able to send intake paperwork)	
INSURANCE INFORMATION	
Insurance Type:	

Member/Client ID#: & Policy Holder Name and Relationship to Client:	
PRESENTING PROBLEM & NEEDS	
Presenting problem and services needed: <i>Please chose all services requested.</i> <input type="checkbox"/> Medication Management Only (MM) <input type="checkbox"/> Outpatient Therapy (OPT) <input type="checkbox"/> Intensive In-Home (IIH) <input type="checkbox"/> Day Treatment (DTX) <input type="checkbox"/> Therapeutic Foster Care (TFC) <input type="checkbox"/> Family Centered Treatment (FCT) <input type="checkbox"/> High Fidelity Wrap-Around (HFW) <input type="checkbox"/> To be determined by clinical evaluation	<i>Please detail the nature of the client's presenting problem and behavioral health needs.</i> Please check if in presenting problem: <input type="checkbox"/> Suicidal Ideations <input type="checkbox"/> Homicidal Ideations
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?	
School Name and Grade	
Primary Care Physician and Clinic Name:	