821 S Main Street
Laurinburg NC 28352
Phone: 910-266-0092 Fax: 910-266-0093

REFERRAL FOR SERVICES

Date or Referral: ________________________ Residential County: __________________________

Consumer's Name: __________________________________ Date of Birth: _____________________

Address:____ Social Security # _______________

Phone # _______________ Race: ___________________________

Gender: ____ Male ____ Female

Medicaid: _____ Yes _____ No Medicaid I.D.#: _____________ Other Funding Source_____________

Referral Source Name: ______________________________________ Phone# ___________________

Referral Source Agency: ____

What services are currently being provided to this consumer?

____

Check all that apply:

- ❑ Hospitalized within the year
- ❑ In a detention, prison, or jail within the last year
- ❑ Police have been called to the home due to the client's behavior within the last 12 months
- ❑ Convicted of two or more serious misdemeanors within the past 12 months
- ❑ DSS substantiated report within the last 12 months
- ❑ Currently in DSS custody

Child is involved with:

- ❑ DSS
- ❑ Juvenile Justice
- ❑ DPI/Schools System
- ❑ LME
- ❑ Health Department
- ❑ Community Organizations

Services you wish to receive:

- ❑ SAIOP
- ❑ SACOToikonjm
- ❑ Individual Therapy (Mental Health & Substance Abuse)
- ❑ Group Therapy (Mental Health & Substance Abuse)
- ❑ DWI
- ❑ Sexual Offender Treatment Services

Is the parent/legally responsible party aware of this referral:

- ❑ Yes
- ❑ No

Parent/Guardian's Signature (if available): ____

Additional Problem Areas/Needs and or Comments:

____

____

____

____
Referral Source Signature

For Staff Use Only (Initial & Date):
Staff receiving referral: __________________________
Open Record: Yes ______ No ______
Record# _____________________________________