



Sandhills Behavioral Center, Inc.

402 Harris Ave.
Raeford NC 28376

Phone: 910-848-1638 Fax: 910-848-1639

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



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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

<p>For Staff Use Only (Initial & Date):</p> <p>Staff receiving referral: _____</p> <p>Open Record: Yes _____ No _____</p> <p>Record# _____</p>
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