510 NORTHGATE PARK DR.
Winston-Salem, NC 27106
P: (336) 276-2076
F: (336) 293-8843
WWW.RHCLINICAL.COM

REFERRAL FORM

Referred by: ___________________ Referral's Phone: _______________

Referral's Email: ____

Referring Agency: _________________ Referral Date: ___________________

REQUESTING:

☐Comprehensive Clinical Assessment
☐Intensive Outpatient Services
☐Medication Management
☐Substance Abuse Services
☐Outpatient Services

CONSUMER INFORMATION

Consumer's Name: ____

Date of Birth: ___________________________ Social Security #: _____________________

Medicaid Number: _________________________ Expires: __________________

Street Address: ____

City/State/Zip: ___________________ County: _______________________

Home Phone: ____________________ Work Phone: ____________________

Marital Status: ☐ Married ☐ Single Race/Ethnicity:__________________

Gender: ☐ Male ☐ Female School/Grade:___________________

Email: _______________________________________

Employer's Name: _________________ Occupation: _____________________

Is there a history of treatment? (Please check one) ☐None ☐Unknown ☐Psychiatric ☐Substance Abuse

FUNDING SOURCE

Insurance Name: __________________ Insurance #: ________________

Insurance Name: ___________________ Insurance #: ________________

FAMILY OR LEGAL GUARDIAN INFORMATION

Mother's Name: _______________________ Father's Name: ____________________

If the consumer does not live with either parent who is the legally responsible person?

Person's Name: ____________________ Phone number: ____________________

CURRENT MEDICATIONS (Please include name, frequency, and dosage):

____

PRESENTING PROBLEM OR REASON FOR SEEKING SERVICES: