REFERRAL FORM

Date: ____________

Person Making Referral: __________________________ Contact #: _____________________
Email____ Fax #:___________________________

Name of person to be referred: ____________________ Parent/Guardian: ______________________

Service Recommended: (Please check one or more that apply):
☐ Multi Systemic Therapy ☐ Intensive In Home Services ☐ Medication Management
☐ Outpatient Therapy (Individual/Family/Group) ☐ Comprehensive Clinical Assessment

Street address: _______________________________ ☐ NC Healthchoice ______________________

City/Zip: __________________________________ ☐ Medicaid: _____________________________

Phone: ____________________________________ ☐ Other Insurance:________________________

Alternate Phone: _____________________________

Age: ________ Date of Birth:________________ Social Security Number:_____________________

Gender:_____ Race:______ Language Spoken:________________

Legal:

DJJ Or Legal Involvement? ☐ YES ☐ NO On Probation: ☐ YES ☐ NO

JDD/Court Counselor Name/Contact:____

Medical:

Primary Care Provider (PCP): _______________________ PCP Address: ____________________

PCP Phone: _____________________PCP Fax: _____________________

School Information:

School: __________________________ School Address: __________________________

School Phone: __________________ School Fax: ____________________ Grade: ___________

Identified Problems/Symptoms: (please include reason for referral)

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Fax: (704) 910-1139
Email: info@procureagency.com

Office Use Only

MCO ID #: ______________

Clinician Performing Assessment:

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Date/Time of Assessment:

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