PRIMARY HEALTH CHOICE, INC.

Mental Health & Home Health Services
"Individuals First Choice"

REFERRAL/INQUIRY FOR SERVICES

Date: _____/ _____/_____

Referral Source
☐ Other Provider Agency ☐ DSS Referral ☐ Foster Care Referral ☐ Other_____

☐ Juvenile Justice Referral (Individualized Education Plan or other Behavioral Plan in place?)

☐ School Based Referral (Individualized Education Plan or other Behavioral Plan in place?)

Individual's Information

Name: _____ DOB: _____

Address: _____

_____

Telephone #: _____ School Name: _____

Guardian Name/Contact #: _____

Insurance: ☐ Medicaid ☐Medicare ☐ NCHC ☐ Private Ins. ☐ self pay $_____

Currently do client ☐ hurt self ☐ hurt someone else ☐ problems with drugs or alcohol ☐ behavioral problems at school (Suspensions/IEP/ 504 Behavioral Plan)

☐ Self-help Issues ☐ physical mobility issues ☐ ADL issues ☐ developmental issues ☐ behavioral problems at home

Reason for Referral:
☐ Presenting Problems (If so, BRIEFLY describe):

Services Requested:
☐ NC Innovation Waiver Services ☐Substance Abuse ☐ Psychiatric/Medication Management

☐Home Care Services ☐Therapy Services ☐Intensive In-Home Services

☐Comprehensive Clinical Assessment ☐ Developmental Therapy ☐ Personal Assistance

Name and Contact Number of Person Making Referral:
_____

Referring Agency: _____

Send referral form to the contact person below:

Mail or Fax: Attn: Alice Hunt, COO of Clinical Services
P.O. Box 159
St. Pauls, NC 28384
(910) 865-3500 or Fax (910) 865-4124

Eff. Date: 6/4//2012