

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

Self-help 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

Therapy Services Intensive In-Home Services

Comprehensive Clinical Assessment Developmental Therapy

Name and Contact Number of Person Making Referral:

Referring Agency: _____

Send referral form to the contact person below by email, mail, or fax:

Email: hlocklear@primaryhealthchoice.org
Mail to - Attn: Hollie Locklear, Chief Operating Officer
P.O. Box 159, St. Pauls, NC 28384
(910) 865-3500 or Fax (910) 738-9799

Eff. Date: 6/4//2012