FAMILY SOLUTIONS

REFERRAL FOR MENTAL HEALTH SERVICES

familysolutions
commitment . compassion . community

Client Information:

Client Legal Name:	Date of Birth:	Age:
Race/Ethnicity:	Gender: ☐Male ☐Female ☐Prefer to Describe:	
Marital Status (if minor, select marital status of parents): ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Remarried ☐Partnered	Client's Preferred Pronouns: ☐He/Him/His ☐She/Her/Hers ☐They/Them/Theirs ☐Prefer To Describe: School & Grade (if minor):	
Preferred Service Location: ☐Greensboro Office ☐Archdale/High Point Office ☐Burlington Office		

Contact Information:

Name of Parent/Legal Guardian/Foster Parent or Self: Relationship to the Client:	Residential Address (including zip code):
Contact Information (Include Phone and Email if possible):	Type of Home Setting: ☐Home ☐Foster Home ☐Group Home ☐Psychiatric Hospital ☐Other: (specify):

Insurance/Payment Information:

Type of Insurance: ☐Medicaid, What county/MCO? ☐NC Healthchoice ☐Other:	
Insurance ID #	Issued Date:

Referral Source, DSS, or Primary Care Provider Information:

Name: Phone # Email:	Practice Location & Address:
Has the client or caretaker been informed of this referral? ☐Yes ☐No	

Child/Adult Mental Health Information:

Current Mental Health Medication:	Current DSM-V Diagnosis:
Prescribing Physician Name & Phone #:	Diagnosing Professional's Name & Phone #:
Does this client have accessibility needs or other needs or conditions (such as allergies, seizures etc.)that we need to know? ☐Yes ☐No If Yes, Please Specify:	

Date Rcvd.:_____ ☐ Verified Ins. ☐ Excel ☐ Add to Waitlist ☐ Add/Convert Client ☐ Mail Appt. Letter

Assigned to: _____ Appointment Date: _____ Appointment Time: _____

Reason For Treatment:

In your own words, describe the child/adult/self in need for mental health services. Please describe specific behaviors the child/adult/self is exhibiting:

Desired Treatment Outcomes:

In your own words, describe the results you want for the child/adult/self from receiving mental health services:

Additional Comments or Requests:

Examples of Additional Comments include therapist preferences, former history with agency, siblings in attendance with agency, type of therapy service requested, DSS Custody status and information, client nicknames or preferred names if different than legal name etc.

Client's Weekly Preferred Availability. Please list below days and times you prefer. Understand that some time slots are more requested than others and may not be immediately available.

Monday	Tuesday	Wednesday	Thursday	Friday
Client Availability Notes:				

PLEASE FAX COMPLETED REFERRAL FORM BACK TO 336-899-8811 OR EMAIL TO INTAKE@FAMSOLUTIONS.ORG IF YOU HAVE NOT HEARD BACK FROM US WITHIN 2 BISUNESS DAYS, PLEASE CALL/EMAIL OUR INTAKE TEAM @ 336-899-8800 OR EMAIL INTAKE@FAMSOLUTIONS.ORG