

Caring Hearts Professional Counseling Services, PLLC

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Office (910) 299-0848 Fax (910) 299-0850

930 Cambridge Street-Suite 109 Fayetteville, NC 28303
Office (910) 484-2202 Fax (910) 484-2203

Consumer Referral Form

Date of Referral: _____

MCO Medical Record #: _____

Referral Source

Referral Name: _____ Phone #: _____

Office/Home Address: _____

Demographic Information

Consumer Name: _____ DOB: _____

Address: _____

Social Security #: _____ Gender: Male Female

Client/Patient's Race: _____ Client/Patient's Phone: _____

Insurance Carriers:

Medicaid/NC HealthChoice ID# _____

Tricare _____ Blue Cross/Blue Shield _____

Aetna Military One Source Self Pay Other Insurance (*specify*) _____

Parent/Guardian: _____

Relationship to Consumer: Mother Father Relative Other _____

Parent/Guardian Home # _____ Cell _____ Work _____

Best Time to Contact: _____ Okay to Leave Message: (*check*) YES NO

Treatment History

Diagnosis: _____

Medications and dosage: _____

Education

School _____ Grade: _____

Services Requested: MH Therapy Substance Abuse Therapy Problem Gambling

Reason for Referral: _____

Agency Use ONLY: Status of Referral: _____

Date Contacted: _____ Appointment: _____

Professional Assigned to Case: _____

Confidential Information. Disclosure of confidential information is strictly prohibited without consumer's written consent.