Caring Hearts Professional Counseling Services, PLLC

312 College Street-Suite C Clinton, NC 28328
Office (910) 299-0848 Fax (910) 299-0850

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: _____

****REQUIRED**: Current Risk to Harm Self/Others:**

Consumer Potential Risk to Self: ☐ None ☐ Mild ☐ Moderate ☐ Severe
Consumer Potential Risk to Others: ☐ None ☐ Mild ☐ Moderate ☐ Severe

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.