FAMILY SOLUTIONS

REFERRAL FOR MENTAL HEALTH SERVICES

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Client Information:

Name:	Date of Birth: Age:
Race/Ethnicity:	Gender: ☐ Male ☐ Female ☐ Other
School & Grade:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Preferred Service Location: ☐ Greensboro Office ☐ Archdale/HP Office ☐ Burlington Office	

Contact Information:

Name of Parent/Legal Guardian or Self:	Address:
Relationship to the Client:	
Contact Information:	Type of setting: ☐Home ☐ Group Home ☐ Foster Home ☐Psychiatric hospital ☐ Other (specify):

Insurance/Payment Information:

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

Referral Source/PCP information: Complete this section so we can contact you after the referral is made.

Name:	Mailing Address:
Phone #:	Email Address:
Has the client or caretaker been informed of the referral? ☐ Yes ☐ No	

How did you hear about Family Solutions?

Child/Adult Mental Health Information:

Current Medication:	*Current DSM V Diagnosis:*
Allergies:	
Prescribing Physician Name & Phone #:	Diagnosing Professional's Name & Phone #:

Date Rcvd.: _____ ☐ Excel ☐ Verified Ins. ☐ PIMSY ☐ Mail Appt. Letter ☐ Assigned to: _____

Reason for referral for treatment: In your own words, describe the child/adult/self in need for mental health services. Please describe specific behaviors the child/adult 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: (IE: Therapist preferences, former Client with Agency, Siblings in attendance with Agency, Type of Therapy)

Clients Weekly Preferred Availability. Please list below days and times you prefer:

Monday	Tuesday	Wednesday	Thursday	Friday

PLEASE FAX COMPLETED REFERRAL FORM BACK TO (336) 899-8811. IF YOU HAVE NOT HEARD BACK FROM US WITHIN 2 BUSINESS DAYS, PLEASE CALL/EMAIL OUR INTAKE TEAM @ (336) 899-8800 Option 2 or megan@famsolutions.org