Referral Data Sheet

Date of Referral: _____

Referring Agency:

(Check one): ☐ NC Department of Public Safety/Courts/Probation

☐ Other agency, please list: _____

Referrer Name: _____

Phone Number (_____)-_____-_____

Fax Number: (_____)-_____-_____

Client Demographics

Client Name: _____

Last, First, Middle Initial

Date of Birth: _____

Month/Date/Year

Age:_____

Sex: ☐ Male ☐ Female

Guardianship: Does client have legal guardian? ☐ Yes ☐ No

If yes, please provide documentation of legal guardian. If under 18, parent/guardian signatures will be required at intake for further rendering of services.

Client Contact Information

Address: _____

City:_____

Zip Code:_____

Phone: _____

County of Residence:_____

State: _____

Insurance (please check)

☐ Medicaid

☐ NC Health Choice

☐ Medicare

☐ TRICARE

☐ State Health Plan of NC (BC/BS)

☐ Private Health Insurance, please list: _____

Services Requested

☐ Substance Abuse

☐ Mental Health Services

☐ Family Therapy

☐ Sex Offender

☐ Other service(s), please specify: _____

Thank you for choosing HOPE Counseling and Consulting Service, Inc! We request that you submit all referrals via fax at (336)-631-1948 or drop off to our office located at 8 West Third St., Ste. 555, Winston-Salem, NC 27101.

Clear **Print Form**