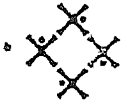

REFERRAL AND SCREENING FORM
THE CARING CLINIC

Referral Date: ______________________

From: ☐ Self/Parent ☐ MH Provider ☐ School ☐ Primary Care Doc ☐ DSS ☐ DJJ ☐ Other ____________

PERSONAL INFORMATION

Name: ______________________ Social Security #: ______________________

Age: __________ DOB: __________ ☐ Male ☐ Female Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ American Indian ☐ Other __________

Primary Language: ______________________

Phone #: ______________________ Alternative #: ______________________

Address: ______________________ County: __________

Emergency Contact: ______________________ Phone #: ______________________

Email Address: ______________________

Urgency (check one): ☐ Routine ☐ Urgent ☐ Emergency
Appointment needed (2 weeks) (48 hours) (24 hours)

Has the client been seen at the Caring Clinic before? ☐ YES ☐ NO When ______________________

Are there any custody or court issues at this time? ☐ YES ☐ NO Explain ______________________

IF UNDER 18

Legal Guardian Name: ______________________ Relationship: ______________________

Guardianship / Custody Documentation? ☐ YES ☐ NO

INSURANCE INFORMATION ☐ Medicaid ☐ NC Health Choice ☐ BCBS ☐ Medcost ☐ UHC ☐ Other

Insurance Policy #: ______________________ If other, name: ______________________

REASON FOR SEEKING TREATMENT

☐ TRAUMA	☐ SAD/WITHDRAWN	☐ GRIEF/LOSS	☐ ANXIETY
☐ RELATIONSHIP ISSUES	☐ SUBSTANCE ABUSE	☐ SLEEP DIFFICULTIES	☐ ANGER/TEMPER
☐ SELF-INJURIOUS	☐ FAMILY STRESS	☐ VERBAL AGGRESSION	☐ DEPRESSION
☐ DISRUPTIVE BEHAVIORS	☐ OPPOSITIONAL (Child)	☐ TRUANCY (Child)	☐ PHYSICALLY AGGRESSIVE
☐ ATTENTION/FOCUS	☐ HYPERACTIVITY	☐ LOW SELF-ESTEEM	☐ SOCIAL SKILLS
☐ MOOD SHIFTS	☐ LEARNING DIFFICULTIES	☐ AUTISM/ASPERGERS	☐ TROUBLE MAKING FRIENDS
☐ HEALTH ISSUES	☐ SUDDEN BEHAVIORAL CHANGE	☐ COGNITIVE DISORDERS	☐ OTHER: __________
☐ PTSD	☐ TRANSGENDER ISSUES	☐ MEDICATION MANAGEMENT (in conjunction with therapy)	

☐ THREAT TO SELF OR OTHERS? If yes please explain: ______________________

FOR OFFICE USE ONLY
Disposition of Referral

Date of first client contact after referral: __________

Does the Caring Clinic meet the needs of the individual above? ☐ Yes ☐ No

Does the request match the Caring Clinic's program? ☐ Yes ☐ No

If yes, first appointment is scheduled for: __________

Anticipated service to be provided: ☐ CCA only ☐ Outpatient ☐ Med Mgmt.

If the Caring Clinic cannot see the client immediately, or if services do not match the program, list referrals made:
____
____
____

Form E2.1 (revised 01/02/2017)