REFERRAL FORM / GENERAL INFORMATION

PO Box 19113, Asheville, NC 28815
Phone: (828) 298-0186 **Fax: (828) 785-1792**

CARING for CHILDREN
a program of Eckerd

Date: _____

PROGRAM REFERRAL:

☐ Therapeutic Foster Care ☐ Outpatient/Psychiatry ☐ Trinity Place Runaway & Homeless Youth Shelter
☐ Level I Foster Care ☐ Angels Watch ☐ PERCS
☐ Cornerstone Independent Living for Girls ☐ Phoenix Homes for Boys ☐ Phoenix Homes for Girls

PERSONAL INFORMATION:

Name: _____ SOC SEC #: _____
Age: _____ DOB: _____ Male ☐ Female: ☐ Race/Ethnicity: _____
Primary Language Spoken: _____ Preferred Language: _____
Phone # _____ Alternate # _____
Address: _____ County: _____

Legal Guardian: _____ Guardianship Documentation? ☐ YES ☐ NO
Guardian Relationship (parent, DSS, self, etc.): _____
Emergency contact: _____ Phone #: _____

INSURANCE INFORMATION: ☐ **MEDICAID** ☐ **NC HEALTH CHOICE** ☐ **OTHER** ☐ **NONE**

INS POLICY #: _____ If other, name: _____
MCO/LME: _____ MCO/LME ID #: _____

SYMPTOM PRESENTATION:

☐ TRAUMA	☐ SAD / WITHDRAWN	☐ GRIEF / LOSS	☐ ANGER / TEMPER
☐ VERBAL AGGRESSION	☐ INTERPERSONAL DEFICITS	☐ PHYSICALLY AGGRESSIVE	☐ DISRUPTIVE BEHAVIORS
☐ OPPOSITIONAL/DEFIANT	☐ FAMILY STRESS	☐ TRUANCY	☐ HYGIENE
☐ ATTENTION / FOCUS	☐ HYPERACTIVE	☐ SLEEP DIFFICULTIES	☐ SOCIAL SKILLS DEFICITS
☐ SELF-INJURIOUS	☐ SUBSTANCE ABUSE	☐ LOW SELF-CONCEPT/ESTEEM	☐ DEPRESSED AFFECT
☐ MOOD SHIFTS	☐ LEARNING DIFFICULTIES	☐ AUTISM / ASPERGERS	☐ NON-ORDINARY BEHAVIORS
☐ HEALTH ISSUES	☐ SUDDEN EMT/BEH CHANGES	☐ COGNITIVE DEFICITS	☐ OTHER : _____

☐ THREAT TO SELF OR OTHERS? If yes, explain:

REFERRER: ☐ MENTAL HEALTH ☐ DSS ☐ DJJ ☐ SCHOOL ☐ OTHER _____

Agency/Org: _____ Rep Name: _____

Phone #: _____ **Referring Provider NPI #**: _____

Has Parent/Guardian been informed regarding this referral? ☐ YES ☐ NO

When do you need services to start? : ☐ Emergent (2 hours) ☐ Urgent (48 hours) ☐ Routine (2 weeks)