The CARING Clinic Referral Form

Mailing Address: PO Box 19113, Asheville, NC 28815
Phone: (828) 298-0186 **Fax: (828) 298-4870**

Date: _____

PERSONAL INFORMATION

Name: _____ Social Security #:_____

Age: _____ DOB:_____ ☐Male ☐Female

Primary Language:_____ Preferred Language:_____

Phone #:_____ Alternative #:_____

Address:_____ County:_____

Emergency Contact:_____ Phone #:_____

IF UNDER 18

Legal Guardian Name:_____ Relationship:_____

Guardianship/Custody Documentation? ☐YES ☐NO

INSURANCE INFORMATION

Insurance Plan Name: _____ Policy #:_____

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☐TRAUMA	☐SAD/WITHDRAWN	☐GRIEF/LOSS	☐ANXIETY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/DEFIANT	☐TRUANCY	☐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:_____

REFERRAL INFORMATION (if applicable): ☐SELF/PARENT ☐MENTAL HEALTH PROVIDER ☐SCHOOL ☐PRIMARY CARE DOCTOR ☐DSS ☐DJJ ☐OTHER:_____

Agency/Org:_____ Rep Name (if known):_____

Phone # (if known):_____