Triad Therapy Mental Health Center, LLC **350 N. Cox St. Suite 201 Asheboro, NC 27203**
Office (336) 629-7774 **REFERRAL FORM** ***Fax (336) 629-7776***

Name:_____ Medicaid# _____

Date of Referral: _____ Medicaid County: _____

Date of Birth: _____ Social Security: _____ Sex: ☐ Male ☐ Female

Address: _____

City: _____ State: __NC_____ Zip Code: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

Referral Source: ☐ Self/No Referral ☐ LME ☐ Hospital ☐ DSS ☐ Schools ☐ Doctor

☐ Family/Relative/Friend ☒ Other: _____

Referral Source's Name: _____ Phone #: _____

Reason for Referral:

_____

_____

☐Housing/Residential ☐Financial ☐Legal ☐Transportation ☐Family Conflicts

☐Emotional/Mental Health Tx ☐Social ☐Medical/Health Issues ☐Safety Issues ☐ Day Program

☐Other(s): List _____

DIAGNOSIS: DSM-V Code and Description and/or Clinical Impression

F Code**:** F Code:

_____ _____

F Code**:** G Code:

_____ _____

F Code**:** M Code:

_____ _____

LEGAL STATUS (Check all that apply):

☐ Competent ☐ Incompetent ☐ Minor ☐ Denies legal history ☐ On Probation/Parole

☐ Juvenile Court ☐ In Jail ☐ Legal history/prior charges (list) _____

GUARDIANSHIP/LEGALLY RESPONSIBLE PERSON/EMERGENCY INFORMATION

Who is Legally Responsible Party? ☐Self ☐Guardian ☐Parent ☐LRP ☐Other _____

Name of Guardian/LRP/Emergency Contact: _____
(Circle all that apply)

Address of Guardian/LRP/Emergency Contact: _____
(Circle all that apply)

Home #: _____ (Work) _____ (Cell) _____

What services does person currently have, if any? _Intensive In-Home_____

What services are you requesting? Out-Patient Mental Health Therapy _____

_____ _____

(Signature & Title of Person Completing Referral) (Date)

Implemented 12/22/2008
Revised March 2018