Date of Referral: _____

Referral Source Name:_____ Referral Source Phone:_____

200 North Greensboro St., Suite C-6, Carr Mill Mall

Carrboro, NC 27510

Phone for referrals: 919.962.3244

Referral Fax: 919.445.0414

General number: 919.962.4919

Center for Excellence in Community Mental Health Referral Form

Name:_____ DOB:_____ Age:_____

Address:_____

County of residence:_____ Gender:_____ Race:_____ Marital Status:_____

Phone:_____ UNC Medical Record# (if available)_____

Does patient have private insurance? Yes/No

If Yes - Insurance Name: _____ Policy #:_____

Does patient have Medicare or Medicaid? Yes/No

If Yes – Medicare#_____ or Medicaid #_____

(If no insurance, advise patient call Sarah Cooper, Financial Counselor 984-974-3931 to apply for Charity Care)

Reason for Referral: *Symptoms/Services requesting* (psychiatric services, therapy, enhanced services)

_____

_____

_____

_____

Current or Past Substance Use? Yes/No (Explain) _____

Current Treatment Provider - Name:_____ Phone:_____

If no current treatment, last treatment was with:
Name:_____ Year:_____

History of MR/Developmental Disabilities/Special Needs?_____

Current/Previous Mental Health Diagnosis:

_____

_____