Date of Referral: ______________________

Referral Source Name:_________________ Referral Source Phone:_________________

URGENT RESPONSE NEEDED WITHIN: [ ] 24h [ ] 48h [ ] 72h

3010 Falstaff Road
Raleigh, NC 27610
Phone: 919-445-0350
Fax: 919-445-0405

UNC STEP Community Clinic – Wake Offices Referral Form

Name:_______________________________________ DOB:______________ Age:________________

FULL Address (#, Street, City, Zip):

____

County of residence : Wake Only Accepted Gender:_____ Race:__________ Marital Status:______

Phone:______________________________ UNC Medical Record#:____________________________

Insurance Name: _______________________________ Policy #:___________________________

Medicare#_______________________________ or Medicaid #___________________________

(If no insurance, advise patient call Sarah Cooper, Financial Counselor 966-0089 to apply for Charity Care)

Family contact (name, relationship, number):____

☐ Patient has a Guardian (name, relationship, contact info): __________________________________

____

Reason for Referral (Symptoms/Possible services needed)?

____

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In order to process a referral, we must have the name of a current or previous mental health or medical provider. Your referral will be returned without this information.

Current Mental Health Treatment Provider: Name:____________________ Phone:_____________

Fax# ______________ Address:_____________________________Last Seen:_________________

If no current treatment, last treatment was with:

Name:____ Dates of Services: ____________________

Current or Past Drug/Alcohol Use? Yes/No (Explain) ____

Current Medical or Primary Care Provider Full Name: ____

Phone:________________ Full address:____

Current Medical Problems? Yes/No Explain:____

History of MR/Developmental Disabilities/Special Needs? (Briefly describe)________________________
____

Diagnosis (*Please note Wake STEP can only serve individuals with schizophrenia, schizoaffective disorder, and bipolar disorder):

____
____

Current Medications

Medication	Dose

Number of Past Hospitalizations: ___________ When was most recent hospitalization? ________________

Location of most recent hospitalization (Name/Address): ____

Appointment Location Preference (Circle): Falstaff SRC ERC NRC

Appointment Time Preference (Circle): Morning or Afternoon

(For Center Use Only):

Disposition Date: ________________ □MD Appt. □ CCA □ Records Needed □Declined

Notes:____
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