

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: 984.974.3987

Referral Fax: 984.974.9646

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:

