HORYZONS CLIENT REFERRAL FORM

*Asterisk indicates fields that need to be complete by the individual completing the referral

*Date:

*Your name:

Client's Information

*Name:

*Age:

MRN (UNC OASIS and Encompass clients only):

*Email:

*Phone:

*Preferred method of contact: ◯ Email ◯ Phone

Diagnosis:

*Clinic:

EPI-NC identifier:

Has the client been actively engaged with medication management at your clinic or with another provider? (Y/N): ◯ YES ◯ NO

Has the client given the referring clinician permission for the Horyzons study team to contact them (the client)? (Y/N): ◯ YES ◯ NO

Clinician's Information

Clinician Information

Clinician Name:

Clinician Email:

Clinician Phone:

Peer Support's Information

Peer Support Information

Is client involved with Peer Support program? (Y/N): ◯ YES ◯ NO

PSS Name:

PSS Email:

PSS Phone:

Study coordinator: Elizabeth Fraser – (208) 967-3976 – erfraser@unc.edu

Additional Notes:

Why do you think this client will be a good fit?

Does the client have a history of risky behavior?

Other relevant comments, such as recent life events, guardianship, etc: