North Carolina
Applicaton for Therapy Services

REFERRAL INFORMATION

Referral Agency/Name: _____ Date of Referral: _____

Phone Number: _____ Fax Number: _____

CLIENT'S INFORMATION

Name: _____ Medicaid Number: _____

Date of Birth: _____ Preferred Name: _____

SSN: _____ *Primary Language: _____ *Gender: ○ Male ○ Female

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Insurance (list all): _____

Current School, if applicable: _____ Grade level, if applicable: _____

Race: ○ White ○ African-American ○ Latino ○ American Indian ○ Multiracial ○ Other: _____

ONLY FOR THOSE 18 YEARS OF AGE AND YOUNGER

Biological/Adoptive Parent(s)

Father's Name: _____ SSN: _____ DOB: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Phone: _____

Race: ○ White ○ African-American ○ Latino ○ American Indian ○ Multiracial ○ Other: _____

Religious or Spiritual Orientation: _____

Mother's Name: _____ SSN: _____ DOB: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Phone: _____

Race: ○ White ○ African-American ○ Latino ○ American Indian ○ Multiracial ○ Other: _____

Religious or Spiritual Orientation: _____

Family Preservation Community Services

CLIENT'S LEGAL CUSTODIAN

Agency/Name:_____ Phone: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

MEDICAL

Significant medical conditions

Include allgergies/diet restrictions or indicate "none known."

Special care accommodations needed

Primary health care provider

Name: _____

Address: _____ Phone Number: _____

Reason for the referral for outpatient therapy services

Additional comments about family and social history

Identify cultural preferences

Mental health diagnoses

Medications

Current Medication: _____ Dosage/Frequency: _____

Current Medication: _____ Dosage/Frequency: _____

Provider for prescribing medications

Name: _____

Address: _____ Phone Number: _____

AUTHORIZATION

I submit this application for review in request for outpatient therapy services with Family Preservation Community Services.

_____ _____

Self/Parent/Legal Custodian/Authorized Representative Date

Family Preservation Community Services