



Creating solutions, One person at a time

Youth/Adult Community Collaborative Referral Form

845 Church St. N.
Suite 208
Concord, NC 28025
Phone: 704-743-2100
Fax: 704-743-2120

Date of Referral: _____

Status of Referral: Emergent Urgent Routine

Referring Agency name: _____ **Contact Person:** _____

Telephone #: _____ **Fax #** _____

Primary Contact: _____

Medicaid: Yes No

Name of Consumer: _____ **Date of Birth:** _____

Legal Guardian: _____ **Telephone #** _____

Address: _____

Reason for Referral: _____

Behavioral Characteristics (please include frequency of behaviors): _____

Current Medications: _____

Diagnostic Impressions: _____

Previous mental health tx (include outcomes): _____

Family hx of MH/SA/DD: Yes No

Multiple agency involvement: Yes No **If so please list:** _____

Additional Comments: _____

Signature of referring agency: _____

