



Referral Form

Form must be **fully** completed and approved by HSOTC **before** client's appointment. **Medicaid** clients must have copy of Medicaid card accompany this form. Medicaid clients that are **Carolina Access Enrollees** must include their Primary Care Physicians Carolina Access Number. Client is not eligible for Medicaid coverage if any part of this form is left blank.

Client Name: _____

Preferred Name: _____ Date of Birth: _____ Present Age: _____

Street Address: _____ City and State: _____ Zip Code: _____

Billing Address (if different): _____

Name(s) of Parent / Legal Guardian: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Presenting Issues: _____

Diagnosis: Axis I: _____ Code: _____

(cannot leave blank) Axis II: _____ Code: _____

Axis III: _____ Code: _____

Desire to Change (circle one): good fair poor

Ability to Change (circle one): good fair poor

Support Systems: _____

Medications: _____

Side Effects: _____

If Client is Carolina Access Enrollee – Carolina Access Number (7-digit number): _____

Primary Care Physician: _____ **Phone:** _____

Name of referring licensed professional: _____ Relationship to client: _____

Referring Organization: _____

Street Address: _____ City & State: _____ Zip Code: _____

Work Phone: _____ Cell Phone: _____ Fax: _____

E-Mail: _____ Best Times to Contact: _____

Signature: _____ Date: _____

****Please attach copy of current Medicaid card with this form****