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| **UNCG PSYCHOLOGY CLINIC**  **Referral For Services** | | | | | | | | |
| **CLIENT INFORMATION** | | | | | | | | |
| **Client Name:** | | | | | **Nickname:** | | | |
| **Street Address:** | | | | | | | | |
| **City:** | | | | | **Zip code:** | | | |
| **Preferred Phone:** | | | | | **OK to leave message YES [ ] NO [ ]** | | | |
| **Other Phone:** | | | | | **OK to leave message YES [ ] NO [ ]** | | | |
| **Age:** | **Date**  **of birth:** | | | | | | **Gender:** | |
| **Insurance:** | | | | | | | | |
| **Does Client have Sandhills Medicaid? YES [ ] NO [ ]** | | | | | **Does Client have any other insurance? YES [ ] NO [ ]** | | | |
| **Previous Treatment? Yes [ ] No [ ]** | | | | | **Medications: Yes [ ] No [ ]** | | | |
| **Service Requested: Therapy [ ] Testing [ ] Other [ ]**  (Details): | | | | | | | | |
| **Completed by:** | | | **Informant:** | | | | | **Date:** |
| **PARENT/GUARDIAN INFORMATION** | | | | | | | | |
| **Name of guardian:** | | | | | | | | |
| **Relationship of the guardian to the client (i.e. mom, dad, aunt, etc):** | | | | | | | | |
| **Who plans to attend appointment?** | | | | | | | | |
| **Notes:** | | | | | | | | |
| **REFERRAL SOURCE INFORMATION** | | | | | | | | |
| **Agency Name:** | | | | **Contact Person:** | | | | |
| **Phone:** | | | | **Fax:** | | | | |
| **INTAKE APPOINTMENT (For Office Use Only)** | | | | | | | | |
| **Date:** | | **Time:** | | | | **Screener:** | | |
| **Phone #:** | | **Primary language: Interpreter [ ]**  **Who:** | | | | | | |
| **Set Intake fee for Self-Pay:**  **Est. Income: Dependents: Intake Evaluation Fee:** | | | | | | | | |

Please fax this referral form along with a **signed Release and Disclosure Form** to the UNCG Psychology Clinic at 336-334-5754. Clinic staff will then contact this potential client to schedule an intake interview and gather any additional information.