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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.