Appointment: _____
Arrived: _____
Seen:_____

229 Turner Drive Reidsville, NC 27320
Phone 336.349.2233 Fax 336.634.0444

Referral Form

"Youth Haven Services supports the healing of children and families through empowerment and hope"

**** (For office use only) ****

1st Contact: Date _____ Time: _____ Comments: ☐ Left message ☐ not available
2nd Contact: Date _____ Time: _____ Comments: ☐ Left message ☐ not available
3rd Contact: Date _____ Time: _____ Comments: ☐ Left message ☐ not available

Date of referral: _____ **Time of Referral** _____ ☐ Phone ☐ Person

Referred by: _____ **Phone #**_____
Referral Source: ☐ School ☐ DJJ ☐ Hospital ☐ LME ☐ DSS ☐ Other: _____
☐ PCP _____ NPI # _____
Is parent/guardian of children/adolescent or adult client aware of this referral? ☐ Yes ☐ No

☐ **Child/Adolescent** ☐ **Adult** ☐ **Male** ☐ ****Female** (**Are you currently pregnant:** ☐ Yes ☐ No)

Client's Name: _____ **DOB**: _____ **Record#:** _____ **SS#:** _____
School Attending: _____ ☐ N/A

Primary Care Physician: _____
Parent/Guardian's Name: _____ **Home/Cell Phone #:** _____
Current Address: _____

Insurance Information: (YHS accepts Medicaid, Health Choice, BCBS, Aetna, and Tri-Care)

Primary Insurance: ☐Medicaid ☐Health Choice ☐ BCBS ☐ Tri-Care ☐ IPRS ☐ Aetna ☐ Cigna ☐ Medicare
☐ United Health Care ☐ Med-cost ☐ other: _____ Insurance Card Number: _____

Secondary Insurance: ☐Medicaid ☐Health Choice ☐ BCBS ☐ Tri-Care ☐ IPRS ☐ Aetna ☐ Cigna ☐ Medicare
☐ United Health Care ☐ Med-cost ☐ other: asdf Insurance Card Number: _____

LME/MCO: ☐ **Center Point** ☐ **Cardinal Innovations** ☐ **Sandhills** ☐ **Partners**

Reason for Referral:

_____
_____
_____

- **Has client recently been discharged from an inpatient psychiatric unit or hospital, a Psychiatric Residential Treatment Facility, or Facility-Based Crisis within past 30 days?**
  ☐ Yes ☐ No **Where:** _____ Discharge date: _____
- **Has client been in a facility operated by the Department of Juvenile Justice or Department of Corrections within past 30 days?** ☐ Yes ☐ No
- **Substance Use:** ☐ Yes ☐ No (If yes, then SASSI needs to be completed at intake)