

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)