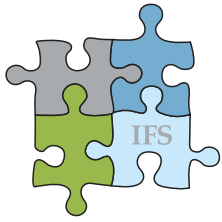


Person completing the form: \_\_\_\_\_



**Integrated Family Services**  
PLLC

## Referral Information

Date: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Client Name: \_\_\_\_\_

Parent/Guardian Name (for minors): \_\_\_\_\_

Client Address: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Medicaid: Yes \_\_\_\_\_ No \_\_\_\_\_ Medicaid ID # \_\_\_\_\_

Carolina Access: Yes \_\_\_\_\_ No \_\_\_\_\_ Carolina Access ID# \_\_\_\_\_

(All Medicaid patients must have this form in their medical records)

Insurance Company (primary): \_\_\_\_\_

Insurance Telephone No.: \_\_\_\_\_

Subscriber I.D. #: \_\_\_\_\_ Group #: \_\_\_\_\_

Problems or Concerns (be specific, include any medication, previous mental health tx, hospitalization, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referral Agency: \_\_\_\_\_ Phone No.: \_\_\_\_\_

(All Medicaid & Health Choice must be referred either by Primary Care Physician or Area Mental Health Program)

Authorization #: \_\_\_\_\_ Record #: \_\_\_\_\_

Number of visits \_\_\_\_\_ Authorization Effective Date: \_\_\_\_\_

Referral done by: \_\_\_\_\_ Date: \_\_\_\_\_

Appointment Date: \_\_\_\_\_ Provider: \_\_\_\_\_

**For Wilson area fax referrals to: (252) 246-9252**

**For Ahoskie area fax referrals to: (252) 209-0488**