Drug Education and Human Development Centers, Inc.

REFERRAL FORM

Client Information

Client's Name: _____
Current Address: _____
Phone Number: _____
Presenting Problems:

_____
_____
_____
_____
_____

Demographic Information

Date of Initial Contact: _____ Date of Birth: _____
Social Security #: _____ Medicaid #: _____
Gender M / F: _____ Client Race: _____
Primary Physician: _____ Medication: _____
Medical History: _____
Psychiatric History: _____

Please describe in detail what the individual is having difficulties with below:

_____
_____
_____

Referring Information

Referring Source: _____ Phone: _____
How did you hear about us: _____

1. Is the client willing to participate in receiving services? Yes / No
2. Is the client currently living in the home? Yes / No
3. Are services able to be delivered in the client's current residence? Yes / No

Individual completing referral: _____ Phone: _____

Signature: _____ Date: _____

P. O. Box 1342, Roanoke Rapids, NC 27870