**InnerVision Referral Form**

**PLEASE COMPLETE AND EMAIL TO:** **SERVICES@INNERVISIONNC.ORG** **OR FAX TO:** **704-377-5043**

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| **Referral Information** |
| Date:  |
| Referral Agency:  |
| Contact Person: |
| Contact Telephone #: |
| Contact Email Address:  |

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| **Client Information** |
| Name:    | Social Security # (if known): |
| Address:  | City, State, Zip Code:  |
| Date of Birth (mo/date/yr):  |
| Telephone number:(cell): (home): (other): |
| **Primary Language** Spanish ( ) English ( ) Other ( ): please specify:**In what language do you prefer to receive InnerVision services? Spanish ( ) English ( ) Other ( ): please specify:** |

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| **Insurance Information** |
| Type of Insurance: [ ]  Medicaid [ ]  None [ ]  Other (i.e. Medicare, Tricare, Private Insurance, etc.) Self- pay [ ]  |
| Insurance ID #:  |
| Mental Health and/or Substance Use Diagnosis (if known):  |
| Special Accommodations Needed: [ ]  No [ ]  Yes If yes, please explain: |

**Please check all the InnerVision services being requested:**

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| [ ]  Assessment (Mental Health and/or Substance Use) [ ]  Parenting classes\*\*\* [ ]  Supported Employment (Individualized Job Placement Services) [ ]  Women’s Book Club\*\*\* [ ]  Outpatient (1:1 Counseling) [ ]  Peer Support Services (1:1 Peer Coach) [ ]  Psychosocial Rehabilitation Day Program [ ]  Life Skills (i.e. Anger Management, Stress Management, Mental Health Education, Drugs and Alcohol Prevention, and  Domestic Violence Prevention classes)\*\*\***\*\*If Applicable, PLEASE INCLUDE A COPY OF THE MOST RECENT ASSESSMENT.** \*\*\*\*\* Currently only available to Spanish speaking participants.  |
| **Reason for Referral** (Why are you referring this individual to InnerVision services at this time) |

**Thank you.**