**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): |

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| **Insurance Information** |
| Type of Insurance: [ ]  Medicaid [ ]  Uninsured [ ]  Other (i.e. Medicare, Tricare, etc.): |
| Insurance ID #:  |
| Mental Health and/or Substance Use Diagnosis (if known):  |
| Special Accommodations Needed:[ ]  Yes [ ]  No If yes, please explain: |

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

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| [ ]  Assessment (Mental Health and Substance Use) [ ]  Substance Abuse Intensive Outpatient Program [ ]  Psychosocial Rehabilitation (Life Skills Day Program) [ ]  Peer Support Services (1:1 Peer Coach)[ ] Supported Employment (Individualized Job Placement Services) [ ]  Outpatient (1:1 Counseling) |
| **Reason for Referral** (Why are you referring this individual to InnerVision services at this time?): |