**InnerVision Referral Form**

**PLEASE COMPLETE AND EMAIL TO :** [**SERVICES@INNERVISIONNC.ORG**](mailto:SERVICES@INNERVISIONNC.ORG) **OR FAX TO:** **704-377-5043**

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

|  |  |
| --- | --- |
| **Client Information** | |
| Name: | Social Security # (if known): |
| Address: | City, State, Zip Code: |
| Date of Birth (mo/date/yr): | |
| Telephone number:(cell): (home): (other): | |

|  |
| --- |
| **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:**

|  |
| --- |
| 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?): |