# REFERRAL FORM

*Fax all referrals to 828-350-0802*

Referral Agency: _____ Referral Date: _____
Referral Phone: _____ Relationship to Client: _____
Client Legal Name: _____ Preferred Name: _____
Social Security # _____ DOB _____ Age_____
☐ Male ☐ Female ☐ Pregnant ☐ IV drug user
Client Phone: _____ Alternate Client Phone: _____
Physical Address: _____
Mailing Address: _____
Legal Guardian: _____ Phone: _____
Address:_____
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
☐ Domestic Partners
Living Arrangement: ☐ Adult Care Home ☐ Homeless/shelter ☐ Private Residence
☐ Other
Insured Name: _____ DOB: _____
Relationship to Insured: _____ Insurance: _____
Benefits Verification Phone: _____
Insured ID # _____ Group #_____
☐ Copy of front and back of card attached
Insured Employer: _____
Medicaid #_____ Medicare # _____
County:_____ ☐ IPRS/Uninsured
Reason for Referral:

_____
_____
_____
_____
_____
_____



119 Tunnel Road, Suite D, Asheville, NC 28805 ▪ Main: 828-350-1000 ▪ Fax: 828-350-0802 ▪ www.octoberroadinc.net

Substance Abuse/Dependency/Treatment:

_____

_____

_____

_____

_____

_____

Positive Drug Screens ☐ Yes ☐ No

Positive for: _____

Current or Previous Diagnosis: _____

_____

_____

☐ Danger to self or others

History of: ☐ Suicidal Ideation ☐ Homicidal Ideation ☐ Legal issues

Details: _____

_____

_____

☐ Psychiatric Hospitalizations

How Many: _____When: _____

Where: _____

_____

☐ Client currently receiving services

Agency Name: _____

Current Medications:_____

_____

_____

_____

☐ Medical Records Attached

Additional Comments/Special Accommodations:

_____

_____

_____

_____

_____

_____

_____

_____



119 Tunnel Road, Suite D, Asheville, NC 28805 ▪ Main: 828-350-1000 ▪ Fax: 828-350-0802 ▪ www.octoberroadinc.net