Center for Child and Family Health
1121 W. Chapel Hill Street, Suite 100
Durham, NC 27701
Tel 919-385-0701 Fax 919-419-9353

***Gray areas for CCFH office use only**
Name of Client _____
DOB _____
CA # _____ Insurance/Medicaid _____

MENTAL HEALTH CLINIC REFERRAL FORM

Referral Source (Name/Agency): _____ Phone: _____

DSS Worker / CPS Investigator: _____ Phone:_____

Name of Child: (Last)_____ (First)_____

DOB: _____ Gender: _____ Age:_____

Primary Language: English / Spanish / Other: _____ Hispanic: Yes / No

Race: _____ 1: *White/Caucasian 2: Black/African American 3: Asian 4: Native American 5: Multicultural 6: Other*

Child lives with: (Name) _____ (Relationship) _____

Client address: _____ City: _____ State: _____ Zip: _____

County of Residence: _____ Caregiver Primary Phone: _____

Provide information on child's primary caregivers, including all those with legal and/or physical custody.

Caregiver #1 Circle: Mother / Father / DSS / Other *If other, please specify*: _____
Circle custody type: Legal / Physical Does the child live with this person? Yes / No
Name: _____ County of Residence: _____
Is address same as client? Yes / No If yes, it is not necessary to duplicate.
Address: _____ City: _____ State: _____ Zip: _____
Phone: (home) _____ (cell) _____ (work) _____

Caregiver #2 Circle: Mother / Father / DSS / Other *If other, please specify*: _____
Circle custody type: Legal / Physical Does the child live with this person? Yes / No
Name: _____ County of Residence: _____
Is address same as client? Yes / No If yes, it is not necessary to duplicate.
Address: _____ City: _____ State: _____ Zip: _____
Phone: (home) _____ (cell) _____ (work) _____

Caregiver #3 Circle: Mother / Father / DSS / Other *If other, please specify*: _____
Circle custody type: Legal / Physical Does the child live with this person? Yes / No
Name: _____ County of Residence: _____
Is address same as client? Yes / No If yes, it is not necessary to duplicate.
Address: _____ City: _____ State: _____ Zip: _____
Phone: (home) _____ (cell) _____ (work) _____

MEDICAID Policy #: _____ County: _____

PRIVATE INSURANCE
Provider Name: _____ Customer Service #: _____
Policy #: _____ Group #: _____
Policy Holder Name: _____ DOB: _____ Gender: F / M
Policy Holder Address:_____City:_____State:_____Zip:_____
Phone: (home) _____ (cell) _____ (work) _____

Primary Care Clinic Name: _____ NPI# _____

Continued on back or next page

School/Daycare: _____ Grade: _____

Child Abuse and Neglect Medical Evaluation (CME) completed Yes / No Date completed: _____

Is the child currently receiving any type of MH services? Yes / No

If yes, with whom, and what type of services? _____

Has anyone in the child's family ever served in the military, including National Guard, Reserve, Active Duty, and Veterans? Yes / No If yes, who? _____

Is the child involved with the juvenile justice system? Y / N

What is the primary reason for this referral? _____

_____

_____

_____

_____

_____

_____

If not described above, is there a trauma in this child's history? _____

_____

_____

_____

_____

Are there any safety concerns for the child or any emergent/crisis-related needs? _____

_____

_____

Emergency Contact: _____ Phone: _____
(Cannot be caregiver) **Name/Relationship** **Circle: home / cell / work**

Please feel free to attach additional pages or send in supplementary information.

CCFH OFFICE USE: Referral Date: _____ Taken by: _____

Appointment Date: _____ Time: _____ Clinician: _____