



Support Incorporated
Solution Station Summer Program 2006
Referral Form

Referral Date: _____ Referral Source: _____ Referral Telephone: _____

Last Name		First Name			Record Number	
Social Security Number	Date of Birth	Age	Race	Gender	County Residency	
Medicaid number	Other Insurance	Target Population		Living Arrangements		
Legal Guardian			Address			
Home telephone		Work telephone		Cellular telephone		

Requesting the Following Service (s):

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Assessment Services | <input type="checkbox"/> Case Management Services | <input type="checkbox"/> CBS | <input type="checkbox"/> Community Support |
| <input type="checkbox"/> Day Treatment | <input type="checkbox"/> Early Intervention | <input type="checkbox"/> In Home Therapy | <input type="checkbox"/> Level III Residential |
| <input type="checkbox"/> Outpatient Therapy Services | <input type="checkbox"/> Psychological Testing | <input type="checkbox"/> School Based Services | |
| <input type="checkbox"/> Other: _____ | | | |

Transportation will NOT be provided for Day Tx. Summer Program (Discuss in CFT Team)

Presenting Problem (including at least two reasons for referrals for case management and/or therapy, as well as diagnosis):

Suicidal/Homicidal Ideation (including any history of psychiatric hospitalizations):

Please list any other agencies that are involved (include contact name and phone number):

- DJJ: _____
- DSS: _____
- GAL: _____
- OTHER: _____
- OTHER: _____

Signature

Date

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Fax 704-482-5236
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Effective 3/06