Referral Info Sheet

Date:____________________ *RHD Program Referring to: ___________________________
Referring Organization: ____
Referral Contact: ________________________________
Telephone: __________________________________ E-mail: ____________________________

Consumer Information

First Name: ____________________M.I __________Last Name: _________________________
DOB: __________ Gender: _____________
Telephone: ____________________ Social Security #: ______________________________
Primary Insurance: _____________________ Policy #: ____________________
Effective Date: ___________
Secondary Insurance: ___________________ Policy #: ____________________
Effective Date: ___________

Current Address: ____
City: _________________________ State: ___________ Zip code: ___________

Current Residence Type: ☐ Group Home ☐ Private Home ☐ Homeless/Unsheltered
Group Home Name (if applicable): _______________________ Telephone: ________________

Current Monthly Income: _______________________
Income Source: ☐ Employment ☐ SSI/ SSDI ☐ NONE

Emergency Contact: ______________________________ Telephone: _____________________
Has a legal guardian: ☐ YES ☐ NO
Legal Guardian Contact: _______________________________ Telephone: _________________

Primary Care Physician: ____
Address: ____ Telephone: ________________
Upcoming Doctor Appointments: ____

ACT Team: ☐ YES ☐ NO
Name and Contact Number: ____

Psychiatrist: ☐ YES ☐ NO
Name and Contact Number: ____

Referral Info Sheet

Requires 24 hour supervision? ☐ Yes ☐ No
Can manage up to 10 hours of unsupervised time? ☐ Yes ☐ No
Diagnosis:

____

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____

Life Domain	Current Functional Status and needs
Psychiatric/Substance Use	
Medical support	
Activities of Daily Living	
Employment	
Family/Social Relationships	
Legal	
Community Inclusion	

Psychiatric Hospitalizations/SA Inpatient/Crisis Episodes (Mobile Crisis, Crisis Center or ER) within the past 12 Months

	Facility and Date
Psychiatric Hospitalization	
Crisis Episodes	
SA Inpatient	

RESOURCES FOR HUMAN DEVELOPMENT

Referral Info Sheet

Please include the following:

☐ Most recent PCP or ISP/B3 Plan
☐ Comprehensive Clinical Assessment
☐ Release of Information
☐ MAR or Medication List

Please list any additional comments or information

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Submit referral and supporting documents to ncreferral@rhd.org

*To find out more about us, please visit rhd.org/nc