



Referral Form

Thank you for this referral. Please complete all sections below with client information.

Full Name: _____ DOB: _____

Address: _____

County: _____ Zip Code: _____

May we send mail to this address? Yes No

Phone Number: _____ Alternative Phone Number: _____

Permission obtained for us to leave a voicemail with name and return phone number? Yes No

Client elects to have email communication: Yes No Email address: _____

If a minor, the name of the legal guardian the client resides with: _____

If being referred through the court has the client applied for reimbursement from victim's comp? Yes No

If yes, please share the name of the assigned case worker. _____

Has the client received counseling or therapy in the past? Yes No

If so, what was the name of the practice or the therapist? _____

Are you aware if any family members are currently receiving behavioral health services through CHA at this time:

Yes No

Please list their full names: _____

If this client is not being referred through the court system then please provide a brief description/reason for referral, e.g., anxiety, depression, postpartum depression, parenting, grief, ADHD, substance use related concerns, other:

Referral Source:

Name: _____ Contact Info: _____ Date of referral: _____

Please share any other relevant information you might think is important here:

We appreciate your time! Please fax referral to (+1) 704-445-7508.

Internal Use Only:

We will follow up within 2 business days.

Date Received: _____

Date/time of initial contact with client: _____ Date/time of scheduled appt: _____

CHA therapist assigned: _____