



# TRANSITIONS

*Harness Your Inner Horse Power*

3184 Polk County Line Road, Rutherfordton, NC 28139 | 828-447-6696 phone | 828-288-4747 fax

## TRANSITIONS REFERRAL FORM

Referring Agency or Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_  
First Middle Last

(Child) Parents' Names: \_\_\_\_\_  
Mother Father

Address: \_\_\_\_\_  
Street City State Zip

Home Phone Number: \_\_\_\_\_ Work/Cell Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Adult Marital Status: \_\_\_\_\_ No. Children: \_\_\_\_\_

Child/Youth School: \_\_\_\_\_ Grade: \_\_\_\_\_

Check what area you need help with (Check all that apply):  Mental Health  Substance Use

Brief statement of Problem/Reason for Referral: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What services are you requesting? \_\_\_\_\_

How long have problems existed? \_\_\_\_\_ Allergies: \_\_\_\_\_

History of Mental Health Issues?  Yes  No Provider: \_\_\_\_\_

History of Alcohol/Drug Abuse?  Yes  No Provider: \_\_\_\_\_

Personal Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance:  None  Medicaid  Medicare  Other \_\_\_\_\_

Appointment with: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_