739 Chappell Drive, Raleigh, NC 27606 | Telephone (919) 832-3909 | Fax (919) 755-742 1| nctlc.org

INDIVIDUAL AND FAMILY SERVICES REFERRAL

CLIENT INFORMATION		
Client's Name:	**Date of Birth**:	**Gender:** ☐ Male ☐ Female ☐ Other
Parent/Guardian Name (if applicable): **Home Phone**: **Cell Phone:**	**Address**: **Email address**:	
Current Living Situation: ☐ **Family Home** ☐ **Group Home** ☐ **Alternative Family Living** ☐ **Homeless Shelter** ☐ **Hotel** ☐ **Apartment** ☐ **Other, please specify:**		
Interpreter Needed: ☐ **Yes** ☐ **No** **If needed, please specify preferred language:**		
Best way to contact client/parent/guardian: ☐ **Phone** ☐ **Email**		
MEDICAL/INSURANCE INFORMATION		
Primary Care Physician Name:		
Phone:	**Fax**:	
☐ **Blue Cross Blue Shield**		
Subscriber ID:	**Group ID**:	
Policyholder:	**Policyholder Date of Birth:**	
☐ **Medicaid**	**ID**:	
☐ **Other Insurance**:		
Subscriber ID:	**Group ID:**	
Policyholder:	**Policyholder Date of Birth:**	

REASON FOR REFERRAL/SERVICES REQUESTED/PRESENTING PROBLEMS	
☐ **Developmental Screening/ IQ testing**	
☐ **Diagnostic Assessment (CCA, ADOS, etc.)**	
☐ **Applied Behavior Analysis (ABA/STAR)**	
☐ **Outpatient Treatment/Therapy (Behavioral Health, Speech, Occupational Therapy, Physical Therapy, Counseling, Positive Parenting Program-Triple P)**	
☐ **Other:**	
Presenting Problems/Specific Concerns:	
RECENT HISTORY	
Previous Therapies (please include agency names and dates):	
Previous Evaluations (please include agency/person and date):	
Previous Diagnosis:	
Previous Diagnosis given by:	
Current Therapies (please include all agencies currently involved with client):	
REFERRAL CONTACT INFORMATION	
Name:	**Agency**:
Phone:	**Email**:
Best way to contact referral source: ☐ Phone ☐ Email	
Parent Signature/Verbal Consent given: ☐ ***Yes***	
PLEASE FORWARD TO INTAKE EITHER OF THE FOLLOWING WAYS:	
Fax: 919-755-7421	***Email: referrals@nctlc.org***