Straight Walk Family Services, Inc

Referral Form

Confidential Document – For Professional Use Only

If you or the client is in a state of crisis or need immediate help for any reason, please refrain from filling out this referral and call 911. If you feel that you are a danger to yourself or others, please refrain from filling out this assessment and call or text 988.

Referral Source Information

Referral Date: _____
Referring Provider/Agency: _____
Contact Person: _____
Phone Number: _____
Fax Number: _____
Email Address: _____
Relationship to Client: ☐ PCP ☐ Therapist ☐ Case Manager ☐ Family ☐ Other: _____

Client Information
Client Name: _____ **Phone Number:** _____
Date of Birth: ____ / ____ / _____ **Gender Identity**: _____
Insurance Provider: _____**Policy Number:** _____
Email Address: _____ **Preferred Language**: _____
Is the Client a Minor? ☐ Yes ☐ No

If Yes, Who Currently Holds Custody of the Minor Child? _____

Home Address: _____
City: _____ **State:** _____ **Zip Code:** _____

Address Presented on Insurance Card: _____
City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact: Does Straight Walk Have Permission to Contact the Emergency Contact if Client is Unable to Be Reached? ☐ Yes ☐ No

- **Name:** _____
- **Address:** _____
- **City:** _____ **State:** _____ **Zip Code:** _____
- **Email:** _____
- **Phone Number:** _____

Please note that the receipt of a referral does not guarantee acceptance into our programs or services. Each referral is carefully reviewed to ensure that our agency is the most appropriate provider to meet the identified needs.

Is the client currently on probation/parole: YES _____ NO _____
Name of Probation/Parole Officer: _____
Phone Number of Probation/Parole Officer: _____
Is the client court ordered to complete: Assessment _____ Treatment _____
Name of Court with Jurisdiction: _____
Phone Number: _____
Judge Presiding: _____

Presenting Issues (check all that apply):
☐ Depression ☐ Anxiety ☐ Substance Use ☐ Trauma/PTSD
☐ Bipolar Disorder ☐ ADHD ☐ Anger Issues
☐ Suicidal Ideation Current Risk Factors: ☐ Suicidal Thoughts ☐ Homicidal Thoughts ☐ Self-Injurious Behavior ☐ Aggressive Behavior ☐ Recent Psychiatric Hospitalization
If yes, please explain: _____
☐ Psychosis ☐ Self-Harm ☐ Family Conflict ☐ Other: _____

Services Requested (check all that apply):
☐ Diagnostic Evaluation/Clinical Assessment ☐ Individual Therapy/ Family Therapy
☐ Group Therapy ☐ Psychiatric Evaluation / Medication Management
☐ Assertive Community Treatment Team ☐ Intensive Outpatient Program (IOP)
☐ Community Support Teams ☐ Peer Support Services ☐ DWI Treatment

Is client open to telehealth for: Assessment _____ Treatment _____

Additional Notes or Relevant Information:

_____

_____

_____

_____

Consent to Release Information (if applicable):

☐ Client has consented to this referral and information exchange
☐ Release of Information attached

Submit referrals to:Christina@straightwalknc.com

Please note that the receipt of a referral does not guarantee acceptance into our programs or services. Each referral is carefully reviewed to ensure that our agency is the most appropriate provider to meet the identified needs.