



Straight Walk Family Services REFERRAL FORM

Fax all referrals to 252-212-5844

Referral Agency: _____ Referral Date: _____

Referral Phone: _____ Relationship to Client: _____

Client Legal Name: _____ Preferred Name: _____

Social Security # _____ DOB _____ Age _____

Male Female Pregnant IV drug user

Client Phone: _____ Alternate Client Phone: _____

Physical Address: _____

Mailing Address: _____

Legal Guardian: _____ Phone: _____

Address: _____

Marital Status: Single Married Separated Divorced Widowed Domestic Partners

Living Arrangement: Adult Care Home Homeless/shelter Private Residence Other

Insured Name: _____ DOB: _____

Relationship to Insured: _____ Insurance: _____

Benefits Verification Phone: _____

Insured ID # _____ Group # _____

Copy of front and back of card attached

Insured Employer: _____

Medicaid# _____ Medicare# _____

County: _____ IPRS/Uninsured

Reason for Referral: _____

Substance Abuse/Dependency/Treatment:

Positive Drug Screens Yes No

Positive for:

Current or Previous Diagnosis:

Danger to self or others

History of: Suicidal Ideation Homicidal Ideation Legal issues

Details: _____

Psychiatric Hospitalizations

How Many: _____ When: _____

Where: _____

Client currently receiving services

Agency Name: _____

Current

Medications: _____

Medical Records Attached

Additional Comments/Special Accommodations:
