**InnerVision Referral Form**

**PLEASE COMPLETE AND EMAIL TO:** [**SERVICES@INNERVISIONNC.ORG**](mailto:SERVICES@INNERVISIONNC.ORG) **OR FAX TO:** **704-377-5043**

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| **Referral Information** |
| Date: |
| Referral Agency: |
| Contact Person: |
| Contact Telephone #: |
| Contact Email Address: |

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| **Client Information** | |
| Name: | Social Security # (if known): |
| Address: | City, State, Zip Code: |
| Date of Birth (mo/date/yr): | |
| Telephone number:(cell): (home): (other): | |
| **Primary Language** Spanish ( ) English ( ) Other ( ): please specify:  **In what language do you prefer to receive InnerVision services? Spanish ( ) English ( ) Other ( ): please specify:** | |

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| **Insurance Information** |
| Type of Insurance:  Medicaid  None  Other (i.e. Medicare, Tricare, Private Insurance, etc.) Self- pay |
| Insurance ID #: |
| Mental Health and/or Substance Use Diagnosis (if known): |
| Special Accommodations Needed:  No  Yes If yes, please explain: |

**Please check all the InnerVision services being requested:**

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| Assessment (Mental Health and/or Substance Use)  Parenting classes\*\*\*  Supported Employment (Individualized Job Placement Services)  Women’s Book Club\*\*\*  Outpatient (1:1 Counseling)  Peer Support Services (1:1 Peer Coach)  Psychosocial Rehabilitation Day Program  Life Skills (i.e. Anger Management, Stress Management, Mental Health Education, Drugs and Alcohol Prevention, and  Domestic Violence Prevention classes)\*\*\*  **\*\*If Applicable, PLEASE INCLUDE A COPY OF THE MOST RECENT ASSESSMENT.** \*\*  \*\*\* Currently only available to Spanish speaking participants. |
| **Reason for Referral** (Why are you referring this individual to InnerVision services at this time) |

**Thank you.**