Alternative LIVINGsolutions

Community Agency Referral Form

Date of Referral: _____________

Referred by (Name of Authorized Referrer): ______________________________

Referring Agency: ____

Address:____

Phone:(____)____________**Fax:**(____)_____________**Email:**___________________

Clients Name: ____

DOB:_____________________ **Gender:** ☐ **Female** ☐ **Male** ☐ **Transgender**

Parent's Name (if patient is a minor): ____________________________________

Home:(____)_____________**Work:**(____)______________**Cell:**(____)_____________

Patient's Address: ____

Referral Information:

Program Referral Type (check all that apply):

☐ Outpatient Therapy

- ☐ Behavior Health
- ☐ Substance Use Disorder
- ☐ Psychological Evaluations

☐ Case Management

- ☐ HIV Case Management
- ☐ Substance Use Disorder

☐ Vocational Rehabilitation Services

- ☐ Psychological Services
- ☐ Career Counseling
- ☐ Ticket to Work

☐ **Is client aware that he/she is being referred for Services with Alternative Living Solutions.** ☐ Yes ☐ No

Medications List (if known):

_______________ _____ ____________

_______________ _____ ____________

_______________ _____ ____________

History of Behaviors:

☐ Violent ☐ Abusive ☐ Sexually Inappropriate ☐ Other: _______________________

Presenting Needs/ Reason for Referral:

____

____

_________________________ ________

Signature of Authorized Referrer **Date**

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Referral Checklist

To ensure accuracy and a complete referral, please verify that each listed item has been addressed prior to submission.

☐ Completed referral form, each question has been addressed, with the appropriate answer or with an N/A.

For Outpatient Therapy

☐ Proof of Behavioral Health Disorder
☐ Proof of Substance Use Disorder

For Case Management

☐ Proof of HIV Positive Status
☐ Proof of Substance Use Disorder

For Vocational Rehabilitation Program

☐ Proof of verifiable Physical Disability
☐ Proof of Mental Health Disability

Funding Source

☐ AETNA ☐ Blue Cross Blue Shield of NC ☐ OPTUM
☐ Magellan Behavioral Health ☐ Medicaid ☐ Medicare
☐ Tricare ☐ United Behavioral Health ☐ Value Options
☐ Ticket to Work ☐ NC Vocational Rehabilitation ☐ Self-Pay
☐ Employment Assistance Programs (EAP):

____

Service Location

☐ Alternative Living Solutions – Main
☐ Alternative Living Solutions – Alamance
☐ Alternative Living Solutions – Concord
☐ Alternative Living Solutions – Union

Check all that applies

______________________________ ________________________

Signature of Referrer **Date**

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