FIRST STEP SERVICES, LLC REFERRAL

REFERRAL INFORMATION

Date of Referral: _____ / _____ / _____

Phone: _____ Email: _____

Reason for Referral: _____ Mental Health Services _____ Substance Use Services _____ Other

Details:

_____

Has client previously had an assessment? _____ Yes _____ No If so, when? _____

Is there an existing Mental Health and/or Substance Use diagnosis? _____ Yes _____ No

If so, list all diagnoses:

_____

CLIENT INFORMATION

Client Name – Last: _____ First: _____ MI: _____

Date of Birth: _____ / _____ / _____ Sex: Male☐Female☐ Social Security #: _____

INSURANCE INFORMATION *(if known)*

Primary Insurance Company: _____

ID Policy #: _____ Group #: _____

Claims Address: _____

Phone #: _____

Policy Holder's Name *(if different than client)*:

Name – Last: _____ First: _____ MI: _____

Date of Birth: _____ / _____ / _____ Sex: Male☐Female☐ Social Security #: _____

Phone #: _____ Effective Date of Insurance: _____ / _____ / _____

Patient Relationship to Insured: Self ☐Spouse☐ Child ☐ Other _____

Notes:

RALEIGH
211 E. Six Forks Rd. Ste 117
(919)833-8899
Fax (919)833-4485

CARY
128 Quade Dr.
(919)651-8349
Fax (919)651-0113