Positive Progress Services

Referral Form

''Helping Families One Home at a Time''

Referral for: ☐ Mental Health ☐ substance Abuse

☐ Emergent (1 Hour) ☐ Urgent (48 Hours) ☐ Routine (7-14days)

Date of Referral:_____ Referring Agency/Location:_____

Referring Agency Malling Address:_____

Referring Agency Phone: (_____)_____ FAX:(_____)_____

Client Name:_____

Age/DOB:._____/_____ SSN:_____ Race:_____ Sex:_____ Marital Status:_____

Client Address (Mailing):_____

Client Address (Residential):_____

Telephone #: (Home)_____ (work)_____ (Emergency)_____

Directions to home:_____

_____

Parent/Guardian/Next of Kin:_____

Complaint/Presenting Problem (reason for referral): _____

_____

DIAGNOSIS: Axis I:_____

Axis II:_____

Axis III: _____

Axis IV: _____

Axis V: GAF Current_____ Highest in Past Year_____

Disposition:_____

_____

_____

Signature:_____

M.R.#:_____ Medicaid ID#:_____

Please Mail, Fax or Email: Referral Form to:
Positive Progress Services
305 East 3rd Street, Suite #5 Pembroke, NC 28372
Mailing: PO BOX 12 Red Springs, NC 28377
Phone: (910) 521-7461 Fax: (910) 521-7463
Email: positiveprogressservicescorp@gmail.com