BEHAVIORAL HEALTH FOR THE DEAF & HARD OF HEARING REFERRAL SHEET

COMPLETE FORM AND ATTACH A RELEASE OF INFORMATION (ROI).

FAX COMPLETED FORMS TO LINDSEY GRAY: 919.250.9817

(PLEASE PRINT CLEARLY)

REFERRAL DATE ___________

CLIENT LAST NAME: ______________________________ CLIENT FIRST NAME: __________________________

GUARDIANS LAST NAME: ______________________ FIRST NAME: _________________________________

DATE OF BIRTH: _______ GENDER: ☐ M ☐ F

ADDRESS: _____________________________________ CITY: ______________________ STATE: NC____

COUNTY: _______________________________ ZIP CODE: _______________

HOME PHONE: ____________________ WORK PHONE: ___________________ CELL PHONE: ______________

(CHECK ALL THAT APPLY):

☐ DEAF ☐ HARD OF HEARING ☐ DEAF-BLIND ☐ OTHER: __________________________________s

BRIEF DESCRIPTION OF CLIENT CONDITION/REASON FOR RHA REFERRAL:

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PERSON MAKING REFERRAL: __________________ REFERRAL AGENCY: __________________________

PHONE NUMBER: ________________________ FAX NUMBER: _____

FOR RHA USE ONLY:

MCO: __________________________ DATE REFERRAL RECEIVED: ___________________

REFERRAL SUPPLIED TO: _____________________________ ROI COMPLETED: YES NO

Last Modified: 07/05/16 Form#: DHH