Triangle Family Services

Building a stronger community by strengthening the family
919.821.0790 x333 | Fax: 919.518.9476

Client Information/Referral

Referral Information

Date of Referral:
Referral Source:
Agency:
Agency Phone:

Services Requested

☐ Outpatient Therapy ☐ Psychiatry – Med Management (only offered in conjunction with therapy at TFS)
Briefly describe why you are referring client:

Client Information

Client Name:	DOB:	SSN:
Client Race:	Gender:	Marital Status:
Client Insurance:	Insurance #, Grp#:	Medical Record #:
Parent/Guardian Name:		
Parent/Guardian home phone:	Work/Cell:	
Parent/Guardian Address:	City:	Zip:
Primary Language Spoken at Home:		
Caregiver's Name if different than Guardian(s):	Phone #:	

Legal Involvement ☐ Yes ☐ No

Other Agencies/Service Providers Involved with Client (e.g., Outpatient Therapist, Psychiatrist, etc.)

Name of Agency/Provider	Contact Name	Contact Phone #

School Currently Attending	Grade

Initial Appointment Screen Questions

Client at hospital, ER, Wake Access Center, or mobile crisis for mental health reasons in past year: ☐ Yes ☐ No
If yes, where and when:
Client has had therapy before: ☐Yes ☐ No If yes, where and when:
Client taking medications for mental health symptoms: ☐Yes ☐ No If yes, please list:

Please email password protected referral form to nmejia@tfsnc.org or fax to 919.518.9476