INFINITE BEGINNINGS, LLC

REFERRAL FORM

Select County Below

Gaston ☐ Lincoln ☐ Cleveland ☐ Watauga ☐ Wilkes ☐ Burkes ☐
Ashe ☐ Avery ☐ Mitchell ☐ Yancey ☐ Catawba ☐ Caldwell ☐

City:___________________________________

Referral Name (include Preferred Name):	**Referral Date:**
Referral Phone #:	**DOB:** **Social Security#:** **Medicaid # / Pending Medicaid#:** **MCO ID, if applicable:**
Referral Address:	
Referred Service (Check): ☐ Individual Support Services ☐ Medication Management ☐ Out Patient Therapy Services ☐ Psychosocial Rehabilitation ☐ Peer Support Services ☐ Substance Abuse Intensive Outpatient ☐ Telepsychiatry	**Homeless:** ☐ Yes ☐ No
Reason for Referral/Presenting Problem(s):	
Referral Made By (Check one): ☐ Self: ☐ Doctor:________________ ☐ Community Agency / Hospital / MCO: _________________________	**Phone # of Referral Source:**
MCO Care Coordinator (Check): ☐ Yes ☐ No	**MCO Care Coordinator Name & Phone #:**
Primary Care Physician / Psychiatrist:	**Is Referral receiving additional services from another agency / service provider?** ☐ Yes ; ____ ☐ No
Gender: ☐ Male ☐ Female	**Guardianship:** ☐ Own Guardian ☐ Adjudicated Incompetent **Name of Guardian:** ***Attach documentation with State Seal***
Race: ☐ African American/ Black ☐ Alaska Native ☐ White/ Anglo/ Caucasian ☐ Asian ☐ Multiracial ☐ Pacific Islander ☐ American Indian/ Native American ☐ _________________________	
Marital Status: ☐ Married ☐ Single	**Diagnosis Information:**

- **All Referrals will be seen for intake to engagement within 7 business days.**
- **Please include most current evaluation and plan of care/PCP, if applicable, with Referral Form**
- **Referral form (and additional docs, if applicable) can be sent via confidential fax, mailed, or password protected scanned document**
  Fax: 704-215-5990 Attn: Tequila Sanford or email @ tsanford@infinitebeginningsnc.org