Infinite Beginnings, LLC

Referral Form

Select County	Gaston	Cleveland	Lincoln	Watauga	Wilkes	Burke	City:
	Avery	Catawba	Yancey	Ashe	Mitchell	Caldwell	New Client ☐ Existing Client ☐

Referral Demographics.		
Name:	Referral Date:	
Address:	DOB:	Age:
	SSN:	
Email:	Medicaid No:	
Phone No:	MEDICAID ONLY	
Marital Status:	Race:	
Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them	Living arrangement: ☐Homeless ☐Unsheltered ☐ Other Explain:	
	Guardianship: ☐Own Guardian ☐Adjudicated Incompetent	
Guardian Name:	Guardian Phone No:	

Referred Service: ☐Psychosocial Rehabilitation ☐Peer Support Service ☐Out-Patient Therapy Service	Reason for Referral:
	Referral made by: ☐Self ☐Doctor ☐Community Agency/Hosp/MCO:
Care Management Name and Phone No.:	Phone No. of Referral source:

Diagnosis Information:	Primary Care Physician / Psychiatrist:
Tailored Care Management: ☐Yes ☐No Explain:	Is Referral receiving services from another Agency or Service provider: ☐No ☐Yes Explain:

- All Referrals will be seen for intake to engagement within seven (7) business days.
- Please include most current evaluation and PCP, if applicable, for Referral
- Referral form (and additional docs, if applicable) can be sent via confidential fax, mailed, or password protected scanned documents Fax: 828-537-4938 Attn: Referral.
- Or Call Phone No: 704-671-4047