Residential Referral

116 Health Drive
Greenville, NC 27834
tel 252-413-1950 fax 252-413-0500

PORT HEALTH

Date of referral _____ Date teen available for admission _____

Person Served Information

Person served full name and preferred name (if applicable):

_____

Date of birth _____ Gender: M ◉ F ○ Social security number _____

Parent/guardian name: _____

Contact phone numbers for parent/guardian: _____

Address of teen (if teen is placed outside of home, please indicate and explain in comment section):

_____

Address of parent/guardian (if different from teen):

_____

Reason for referral and presenting problem: _____

_____

General statement about challenges the teen is experiencing with family, school, home, or legal:

_____

_____

_____

Diagnosis:

_____

_____

_____

_____

Substances used/misused by teen:

○ Alcohol ○ Marijuana ○ Pain pills
○ Heroin ○ Benzodiazepines
○ Over-the-Counter medications
○ Cocaine ○ IV drug
Other: _____

Past hospitalizations and recent treatment history (please include both inpatient, outpatient, community based services and reason for referral to level of care):

Place and date of service	Type of service	Reason for admission	Comments regarding completion and/or effectiveness

Please list any medical conditions, allergies, or current medication taken by the teen:

_____

_____

A minimal 30-day supply of medications must be provided by the family at time of admission or the teen may not be admitted to the program.

Legal History

Person served is on probation: Yes ◉ No ○ **if yes:** Adult ◉ Juvenile ○

Name of court counselor(s): _____

Contact number for court counselor: _____

Current pending charges: _____

Court dates that will occur while teen is in treatment at PORT Health: _____

School History

Is teen currently enrolled in school? Yes ◉ No ○ **Name of school:** _____

IEP or 504 plan currently ◉ **IEP or 504 plan in the past** ○

Is the teen or family interested in GED: Yes ◉ No ○

Referral Information

Referring Agency/Person: _____

_____

Address _____

_____

Contact Information for Referring Agency

phone _____ fax _____

email _____

Insurance Information

Insurance Provider: _____ Policy Number: _____

Copy of insurance card must be presented at time of screening, however you may attach a copy to the referral form as well.

Copy of insurance card is attached: Yes ◉ No ○

Required Items/Documents for Admission

- ○ TB Skin Test and record of physical exam
- ○ Insurance Card
- ○ Minimum 30-day supply of all medications
- ○ Documents to support past treatment history
- ○ Any pertinent court documents
- ○ Evidence of a 504 or IEP (if applicable)

Signature of Referring Person: _____ Date _____

For Internal Use only

Date Referral Received _____

Signature of PORT Health staff who received the referral: _____

Date of Scheduled Screening _____