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 ___/___/___

Patient 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 ◯ Benzodiazepines
◯ Heroin ◯ Pain Pills ◯ Meth
◯ Over-the-Counter medications
◯ Tobacco/Vape/Smokeless Tobacco/Cigarettes
◯ Cocaine ◯ IV drug use
◯ 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

Teen 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** ◯ **No IEP or 504** ◯

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 (required at admission)
- ◯ Insurance Card
- ◯ Documents to support past treatment history
- ◯ Any pertinent court documents
- ◯ Evidence of a 504 or IEP (if applicable)
- ◯ Medical history for pre-existing medical conditions

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 ___/___/___