PORT
Human Services
116 Health Drive
Greenville, NC 27834
Phone: (252) 413-1950
Fax: (252) 413-0500

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, and legal:		
Diagnosis:	Substances Used/Misused by Teen: Alcohol ☐ Marijuana ☐ Pain Pills ☐ Heroin: ☐ Benzodiazepines ☐ Over the counter Medications ☐ Cocaine ☐ Other: _____ IV drug use ☐	

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, 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:
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:	Contact Information for Referring Agency
Address:	Phone:
	Fax:
	E-mail for referring person:
Insurance Information:	
Insurance Provider:	Policy Number:

Copy of card must be presented at time of screening, however you may attached a copy to the referral form as well. Copy of 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 staff who received the referral:
Date of Scheduled Screening: