Hope Services, LLC
Empowering people to live successful, productive lives

3000 Highwoods Blvd, Suite 310, Raleigh, NC 27604

(919) 714-7500 **Fax (919) 714-7513**

Hope Services Referral Form

IF THE PATIENT IS IN ENHANCHED SERVICES AT THE TIME OF THIS REFERRAL, THIS FORM MUST BE ACCOMPANIED BY THE CURRENT PCP

Referral

Referral Source:_____ Phone:_____

Name of Person Referring:_____

Primary Care Provider/Doctor:_____ Phone:_____

Services Requested

☐ Assessment ☐ OPT ☐ Intensive In Home ☐ Psychiatric Services

*__Ray of Hope__ ☐ Day Treatment (Raleigh)

*__Light of Hope__ ☐ Day Treatment (Johnston County) ☐ DBT Group

☐ Other

*Ray of Hope is located at 2900 Kidd Rd, Raleigh, Nc 27610
*Light of Hope is located at 1329 N Brightleaf Blvd, Building D, Smithfield, NC 27577

Primary Language

Primary Language of the Patient:_____

Primary Language of the Family:_____

Patient Information

Date:_____

First Name:_____ Middle Initial:_____ Last Name:_____

DOB:_____ Sex:_____ Race:_____

**Email:_____ **Phone:_____

Street Address:_____City:_____ State:_____

Zip Code:_____ County:_____

Patient in DSS Custody:☐Yes ☐No

**REFERRAL FORMS WITHOUT A VALID EMAIL AND PHONE NUMBER CANNOT BE PROCESSED.

Insurance

Primary:_____ Policy #:_____ Member code:_____

Secondary:_____ Policy #:_____

If Subscriber Is Not the Patient:

Subscriber Name:_____ Subscriber DOB:_____

Legal Guardian Information

☐Legal Guardian Information N/A

First Name:_____ Last Name:_____ Address:_____

Relation to Patient:_____ Email:_____ Phone:_____

School

☐School Information N/A

School:_____ Grade:_____

IEP:☐Yes ☐No Developmental Delays:_____

Employment

☐Employment Information N/A

Employment:_____

Other Professionals Involved (Title/Name/Phone/DJJ):_____

History

Previous Mental Health Hx/Trauma Hx:_____ Diagnosis:_____

Substance Abuse/Use:_____IQ/Level of Functioning:_____

Presenting Problem:_____ Legal Involvement:_____

Assistive Technology Needs:_____