



3000 Highwoods Blvd, Suite 310, Raleigh, NC 27604

(919) 714-7500

Fax (919) 714-7513

## Hope Services Referral Form

**IF THE PATIENT IS IN ENHANCED 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: \_\_\_\_\_