Echelon Care
10400 Mallard Creek Rd., Ste# 206
Charlotte, N.C. 28262
704.594.9119 (office) 704.594.9915 (fax)

Office: 704-594-9119 x15
Email: referrals@echeloncare.com
Fax to: 704-594-9915

Screening/Referral Form

I. REFERRAL INFORMATION:

Date:		**Recorded By:**		**Phone #:**	
Referral Source:				**Email Address:**	
Address:				**Phone #:**	
City/State/Zip:				**Fax #:**	

II. CLIENT INFORMATION:

Client Name:		**Date of Birth:**		**Age:**	
Soc. Sec. No:		**Record #:**			
Gender:	☐ **Male** ☐ **Female**	**Race/Ethnicity:**			
Height (approx.)		**Weight (approx.)**			
Address:		**City/State/Zip:**			
Living Situation:		**Phone #:**			
Work #:		**Alt. Contact #:**			

III. PARENT/GUARDIAN/SERVICE INFORMATION:

Parent/Guardian:		**Phone #:**	
Relation to client:	☐ Natural Parent ☐ Self ☐ Foster/Adoptive Parent ☐Grandparent/Other Relative ☐	**Alternate Number:**	
Address			
Reason for Referral:	**Relevant Medical Issues:** ☐ **Yes** ☐ **No If yes, please explain:**		
Service(s) Requested:	☐ Consultation Only ☐ Clinical Assessment ☐ Diagnostic Assessment ☐ Outpatient Therapy: ☐ Individual ☐ Family ☐ Group ☐ Medication Management ☐ Res. Tx. Level III Services ☐ Intensive In-Home Services ☐ MH/SU C&A Day Treatment ☐ B3 Supported Employment Services ☐ Innovations Waiver Supported Employment Services ☐ Personal Care Services ☐ Innovations Waiver Home & Community Supports ☐ Innovations Waiver Primary Crisis Response ☐ Home Care Services		

IV. CURRENTLY RECEIVING SERVICES (IF SO, WHAT KIND, FROM WHERE?):

Yes/No:	☐ **Yes** ☐ **No**	**Type of Service:**	
Agency?:		**How Long?:**	

V. INSURANCE/BILLING INFORMATION:

Type of Insurance:	Medicaid	**ID#:**	
County Code/Name of Origin		**MCO**	
Referring Physician/Center: (Outpatient Only)		**NPI #:**	
Address and Telephone Number:			
Secondary Insurer:		**ID#:**	

VI. AUTHORIZATION: *(For Office Use Only- Do not write below this line)*

Unmanaged Units Available	☐ **Yes** ☐ **No**	**# of Units Left:**	☐ **N/A**
Insurance Verified	☐ **Yes** ☐ **No**	**Expiration Date:**	

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For Clinical Team Only: Do Not Write Below This Line

Referral Status Contact: ☐ Emergent (2 hours) ☐ Urgent (48 hours) ☒ Routine (14 days)

☐ **Referral to emergency services**: _____
☐ **Hospitalization Required:** _____
☐ **Schedule follow up session on:** _____
☐ **Further assessments needed:** _____
☐ **Referral for services:** _____

Referral Disposition:

☐ **Approved**: _____
☐ **Pended:** _____
☐ **Denied:** _____

Recommendations:

_____

_____

_____

_____

_____

_____

Reviewed by: _____ **Date:** _____

Assigned to: _____ **Date:** _____

Clinical Director: _____ **Date:** _____

Medical Director: _____ **Date:** _____