# Clinical Referral Form

**Send completed form to:** Referrals@mtncac.org
**Phone Number for Questions:** (828) 609-6222

**Miranda Bingham (Clinical Family Advocate) coordinates all referrals. All questions may be directed to her via the phone number or email above.**

*If you are a referring a child who has an active Foster Care or Family In Home case through Buncombe County DHHS, referral must be made by child's Social Worker.

**Please complete all fields on the referral form. Referrals with missing information cannot be processed.**

Date of Referral: ___________________ Person making referral: ____________________________

Ph #: ______________________________ Email Address: _____________________________________

Referral is for: ☐Child OR ☐Adult

Client's Name: ___________________________________ DOB: _____________ Gender: ___________

Address: _______________________________________________________________________________

Primary Language: _______________________ Race: __________________________________

Insurance Type: ______________________________ Ph # (For adult referrals): __________________

Name of Current Caregiver: __________________ Relationship: _____________________

Ph #: ______________________________________ Email Address: __________________________

Members of Household:

| Name | Age | Relationship to Child |
|---|---|---|
| 1. ______________________ | _____________ | _______________________________ |
| 2. ______________________ | _____________ | _______________________________ |
| 3. ______________________ | _____________ | _______________________________ |
| 4. ______________________ | _____________ | _______________________________ |
| 5. ______________________ | _____________ | _______________________________ |

**Availability (Days of the week & time of day) : ____________________________________________**

*Specific days/times cannot be guaranteed and are subject to therapist availability. Requesting after school appointment times may lead to an increased wait to begin services.

## Additional Information

Reason for Referral & Symptoms (Please be as detailed as possible):

Please list relevant trauma history including any alleged abuse or neglect (Referrals involving allegations of abuse or neglect that have not been reported will not be accepted until report has been made):

Other Agencies Involved with Child/Family:

______________________________________________________________________________

Court Involvement (DA, Family Court, Juvenile Court Services, Custody, Other):

______________________________________________________________________________

School Involvement (special programs, problems, contact person):

______________________________________________________________________________

**Has child had a Forensic Interview?** ☐No ☐Yes- Date____________________

**Special Classifications**
**(Please check all that apply)**:

- ☐ Deaf/Hard of Hearing
- ☐ Homeless
- ☐ Immigrants/Refugees
- ☐ LGBTQIA+
- ☐ Disabilities
- ☐ Limited English Proficiency
- ☐ Veteran
- ☐ Other

**FOR OFFICE USE ONLY:**

Received:__________
Called:____________
SDQ:______________
Assigned to:________
Date Assigned:_________

Added to Apricot
Referral Uploaded
Intake/Re-Entry Date Correct
BCDHHS Contract Checkbox
1st Encounter Note
Active & Assigned
Assignment Encounter Note

**Thank you for taking the time to make this referral.**

Notes: