

*All Referrals should be sent to our Referral Department:*  
Email: [corporate@pinnaclefamilyservices.org](mailto:corporate@pinnaclefamilyservices.org) Phone: 919-790-8580 Fax: 919-866-3255

## Pinnacle Family Services

### Referral for Services

<b>Date of Referral:</b>	
<b>Name of Person Making Referral:</b>	
<b>Company Name/Relationship to Individual:</b>	
<b>Phone Number:</b>	<b>Email Address:</b>

<b>Name of Person being Referred:</b>	<b>Sex: Male / Female</b>
<b>Birth Date:</b>	<b>Medicaid ID#:</b>
<b>Address:</b>	
<b>County:</b>	

<b>Legal Guardian Name:</b>		
<b>Relationship to Individual Being Referred:</b>		
<b>Home Phone:</b>	<b>Cell Phone:</b>	<b>Work Phone:</b>

**Service Being Requested:**

- Foster Care
- Home-Based Therapy Services (IHH, FCT, IHTS)
- Outpatient
- Unsure/Unknown

**Insurance Information:**

**Primary Insurance:** \_\_\_\_\_  
**Policy Holder Name:** \_\_\_\_\_  
**Insurance ID#:** \_\_\_\_\_

<b>Reason for Referral/Request:</b>          
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