

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

Pinnacle Family Services

Referral for Services

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

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

Legal Guardian Name:		
Relationship to Individual Being Referred:		
Home Phone:	Cell Phone:	Work Phone:

Service Being Requested:

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

Insurance Information:

Primary Insurance: _____
Policy Holder Name: _____
Insurance ID#: _____

Reason for Referral/Request:
