Cedric Dean Holdings, Inc.
Referral Request for Evaluation and Treatment

Date of Referral: _____

Referring Agency: _____

Referring Provider/Contact: _____ **Phone:** _____ **Fax:** _____

Please Check Preferred Evaluation and Treatment:

- ❑ Case Management
- ❑ Care Coordination
- ❑ Peer Support
- ❑ Assessment
- ❑ Individual and Group Treatment
- ❑ Assistance with Daily Living
- ❑ Transitional Housing
- ❑ Supported Employment

Patient Medical Information (please print)

Patient Referred: _____ **DOB:** _____

(Last, First, MI) (Phone)

Parent/Guardian_____

(Name) (Phone)

Reason for Referral: _____

Requested CDH Service:

- ❑ Assessment
- ❑ Case Management
- ❑ Individual / Group Treatment
- ❑ Supported Employment
- ❑ Peer Support
- ❑ Transitional Housing
- ❑ Judicial Recommendation
- ❑ Other _____

Patient's Primary Medical Diagnosis: _____

Other Medical Diagnoses: _____

REFERRAL SIGNATURE_____ **DATE:** _____

To Schedule call (704) 492-1533 (Access to Care) or Fax form to (704) 274-5556

Appt. Date: _____ **Time:** _____**AM/PM** **Scheduled with:** _____

Revised: 9-22-23