Cedric Dean Holdings, Inc. <u>Referral Request for Evaluation and Treatment</u>

Date of Referral:			
Referring Agency:			
Referring Provider/Contact:	Phone:		Fax:
Please Check Preferred Evaluation and Tre	eatment:		
☐ 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	Transitional Housing		
Individual / Group Treatment	Judicial Recommendation		
Supported Employment			
☐ Peer Support	☐ Other		
Patient's Primary Medical Diagnosis:			
Other Medical Diagnoses:			
REFERRAL SIGNATURE		DATE:	
To Schedule call (704) 492-1533 (Access to Care)	or Fax form t	o (704) 274-5556
Appt. Date: Time: AM/PM	Scheduled with:		

The information contained on this form is confidential, privileged, and exempt from discussion under applicable law and is intended only for the purpose of patient referral. Any unauthorized review, use, disclosure, or distribution is prohibited.

Revised: 9-22-23