Precious Haven, Inc.

"Treating Others As We Would Like To Be Treated"
315 Dick Street Fayetteville, NC 28301

Phone: (910) 868-6092 - Fax: (910) 868-8882

Level II] Level III Level IV Ou	tpatient Therapy	
	Referral Form		
Client Name:	Date of Birth:	Age:Race:	
SS#LME Record	#Primary Lang	guage:	
Gender: Male/Female/LGBTQ Medicaid#	Health Choice#	Other:	
Legal Involvement (circle): Yes No Adjudicated (circle): Undisciplined Delinquent Diversion: Contract (circle): Yes No	Current Placement: Teamily Home Group Home/RTC PRTF/Hospital VDC/Detention/Jail	☐ Independent Living ☐ Foster Home ☐ Relative Home ☐ Homeless ☐ Other	
Legal Custodian:	Relationship:		
Client Address:		County:	
Phone #: (home)(or Referral Agency/Name/Phone Number DJJ Case Worker name and Phone # (if apple)			
MCO-Assigned Care Coordinator: (if application of the coordinator)	able):		
Reason for Referral:			
Client has current diagnosis (circle): Yes No	(If yes, please include):		
Aedications: ☐ Yes ☐ No (If yes, please incl	ude):		

Treatment history: : Yes No (If yes, please include):
Medical history: : Yes No (If yes, please include):
Substance Use history: Yes No (If yes, please include information):
Significant Sexual History/Comments: : Yes No (If yes, please include):
Significant Information about DJJ involvment: : Yes No (If yes, please include):
Education information : Grade: Last School attended: HEP/504 plan: Yes No (If yes, please include):

Please complete this form, being sure to indicate the level of care you are seeking, and return the form to our office. In addition to returning the form, please also send the most recent CCA and/or psychological evaluation that recommends the level of care you are seeking, and the current PCP (if available). Once these items have been received by our office, our clinical team will staff the case and someone will be back in touch with you. If you have any questions or concerns, please feel free to give us a call.