REFERRAL FORM

Modern Treatment Healthcare Services

400 Main St. W. Suite 9, Valdese NC 28690

Fax Completed Form to 704-498-4390/ or email to
kbarnes@moderntreatmenthealthcareservices.com

Person Making the Referral:

Prefix | First Name | Last Name | Suffix

DATE

Month | Day | Year

Person Needing Service:

First Name | Middle Name | Last Name

Address

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

Birth date:

Month Day Year

Medicaid #:

Guardian Name:

First Name Middle Name Last Name

Telephone Number

Area Code Phone Number

Email

example@example.com

Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

If applicable:

Does This Person Attend a Day Program?

- ◯ Yes
- ◯ No

Contact Number:

Area Code Phone Number

Services Requested:

- ☐ Psychological Evaluation
- ☐ Outpatient Therapy
- ☐ Assessment
- ☐ Behavior Plan

Please Provide a Brief Explanation of Need:

Date

Month Day Year

Signature

For Office Use Only:

Date Referral was received:

Month Day Year

Type a question

- ○ Was Referral Accepted:
- ○ No (If No, Attach Reason for Denial):