Theo Roach MSW,LCSW,CCSOTS
7512 East Independence Blvd. Suite 104
Charlotte, NC. 28227
www.oasisclinicalcare.net
1-800-581-5907 (fax)
704-536-8382 (office)

REFERRAL FORM

Verbal referrals are always appropriate, but not always possible or efficient. This form will help expedite the request for services. Thanks for taking the time to fill out the form. Please fax it to 1800-581-5907

DATE:

Referring Agency/Individual:

Phone # (referring person) _____Fax# ____

NAME OF CLIENT: _____

Mailing Address: _____

Age/gender: _____

County of Residence/Name of LME: _____

Medicaid #:

Client Phone # _____

Name of Parent/Guardian: _____N/A

BRIEF REASON FOR REFERRAL/CONSULTATION (Please note if there is any urgency, and, if possible, some preferable times):

Office Use Only Please Do Not Write Below This Line

Referral Accepted: **Assigned To:**

Referral Declined: **Initial Appointment Date:**

Reason for Decline: _____ **Time:** _____