Columbia Location **p:** 615-462-6673 **e:** smcclurkan@camelotcare.com

Referral Form

Date: _____ **Referral Agency/Name**: _____

Referral Source's Email: _____**Phone #:** _____ **Fax #:** _____

***Please Check One*:**

	Intensive In Home (CCFT)		**Case Management**		**Outpatient (Indv. or Group)**
	Med Management		**Intensive Outpatient**		**Supervised Visitation**
	A&D Assessment		**DUI School**		**Other:**

Name: _____ D.O.B. _____/____/____ Sex: □Male □Female

Social Security #: _____ Race: _____ Primary Language: _____

Address: _____ Apt #_____

City: _____ State_____ Zip_____ County_____

Parent/Guardian: _____ Contact Phone # (_____)_____

Insurance Co: _____ ☐ Self-Pay ☐ Other: _____

*****The family will be notified within 24 hours or shortly thereafter. Referents will be notified of status*****

Describe the current situation and behaviors leading to the referral::_____

_____

Camelot Use Only:

Insurance Co.:_____ Effective Dates: _____ to _____
Member I.D. #: _____ Co-pay:____/____
Deductible:____/_____ Max Out- of- Pocket: _____ Payout: _____%_____
Prevention Program(s):_____
Max units/days allowed per Calendar Year:_____ Calendar Year Max Used to Date:_____

Admit Diagnosis Code: _____ Licensed Practitioner: _____

Appt. Date(s) Offered: _____ Appt. Date Accepted: _____

Reason for Delayed Appointment (*If First Appointment Date is out of Access Standard Time Frame*): _____

_____

Other Resources Offered (*If Camelot Services are Refused*): _____

_____

Camelot Team Member Date

Revised 11/15