NC Recovery Support Services Inc.

Intake/Referral Form

Consumer Name:	Date of Birth:
Address:	Insurance:
Phone:	Alternate Phone:
Legal Guardian/Phone:	

Time/Date of Intake:	**Referral Source /Phone:**	**Information provided by**
Time:		☐ phone ☐ in person
Date:		
Presenting Concerns and Requested Services		

Immediate Safety Concerns			
Self-Harm / Ideations / Thoughts / Behaviors	☐ In last week	☐ In last month	☐ In last year
Harm to Others / Ideations / Thoughts / Behaviors	☐ In last week	☐ In last month	☐ In last year
Psychosis / Delusions	☐ In last week	☐ In last month	☐ In last year
Withdrawal Symptoms	☐ In last week	☐ In last month	☐ In last year
Domestic Violence	☐ In last week	☐ In last month	☐ In last year

Description of Immediate Safety Concerns:

Current or Recent Psychiatric or Mental Health Services (including hospitalizations):
Previous Diagnoses:

Current or Recent Legal Involvement (charges/ arrests/probation/incarceration):

Current Medical Concerns / Medications:

Vocational / Educational Problems:

Presenting Housing Concerns:

Substance Use/Abuse

Substance	Frequency of use	Amount	Last Use

Other Identified Needs (housing / medical / vocational / educational / legal):

Identified Barriers to Treatment:

Intake/Screening Recommendations

Referral Status
☐ Emergent (consumer seen within 2 hours or referral to emergency services)
☐ Urgent (consumer seen within 48 hours)
☐ Routine (consumer seen within 7 calendar days)

☐ Scheduled Consumer for Clinical or Substance Abuse Assessment		
Location:	Date:	Time:
☐ Other Recommendations or referral activity		
Was referral source contacted re: disposition? ☐ Yes ☐ No ☐ NA		
	If yes, when:	

Was consumer or referral source informed of reasons for specific referrals or eligibility?
☐ Yes ☐ No ☐ NA

Specific Intake/Referral Activity

Employee Completing Screening (print name): _____

Supervisor Signature: _____ Date: _____