APPALACHIAN REGIONAL HEALTHCARE SYSTEM
Charles A. Cannon, Jr. Memorial Hospital

Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

REFERRAL FOR OUTPATIENT BEHAVIORAL HEALTH SERVICES

Charles A. Cannon Jr. Memorial Hospital
436 Hospital Drive, Suite 235
Linville, NC 28646
828-737-7888 (phone)
828-737-7606 (fax)

Date: _____ Full Legal Name of Patient: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female Social Security #: _____

Mailing Address: _____

Marital Status: _____ Mother's Maiden Name (for security purposes only) _____

Telephone: home: _____ cell: _____ work: _____

Employed? ☐ Yes ☐ No

Employer Name: _____

Address: _____

Telephone #: _____

Next of kin Name: _____

Relationship to patient: _____

Address: _____

Telephone #: _____

Is patient receiving Behavioral Health services from anyone else? ☐ Yes ☐ No _____

Health Insurance: _____ Policy # & group #: _____

Medicaid LME: _____ Telephone number of back of insurance card: _____

We must have the following before the patient can be scheduled:

1. **medical records (if applicable)**
2. **most recent labs (if applicable)**
3. **medication list (if applicable)**
4. **front and back of insurance card**
5. **this completed referral**

Type of service requesting:
☐ Medication Management only
☐ Individual Talk Therapy only
☐ Both Medication Management and Individual Talk Therapy

Reason for referral: _____

▶ _____
Signature of referral source **Date/Time**

Office Name: _____ Phone#: _____ Fax#: _____

Effective Date: Not Set
Revised Date: 10/30/2017
Form Number: 11294