Serenity
THERAPEUTIC SERVICES
"We Provide Therapeutic Results"
109 Oakwood Ave.
Raeford, NC 28376
Office: 910-904-7147 Fax: 910-904-7148

Consumer's Full Name: _____ **DOB:** _____

Consumer's Address: _____

_____

Contact Telephone Number: _____

Consumer Record#: _____ **Consumer's Medicaid #:** _____

Gender: Male ™ **Female** ™ **Social Security #:** _____

Do you have a legal guardian (if yes, please provide contact information) Yes ™ **No** ™

Legal Guardian Name: _____ **Phone #:**_____

Referral Source
Name: _____ **Agency:**_____
(Print)
Address:_____

_____

Telephone #: _____ **Fax #:** _____

E-mail:_____

Relationship: ™ **Family Member** ™ **Physician** ™ **Case Manager**
™ **Other**_____

(Please specify)

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1. **Reason for referral/or presenting problem; Residential Placement ™ Targeted Case Management ™ Therapeutic Foster Parent ™**

_____
_____
_____
_____
_____

2. **Current Diagnosis (please be specific)**

Axis	Code	Diagnosis	Date of Diagnosis
AXIS I			
AXIS I			
AXIS I			
AXIS II			
AXIS II			
AXIS III			
AXIS IV			
AXIS V			

3.Please list all medications prescribed with doses. (Attach additional paper if necessary)

_____
_____
_____
_____
_____

4. Please indicate any relevant medical history (include allergies):

_____
_____
_____

5. **Are there any past or current legal concerns? (if yes, please specify and include State and County) Yes _____ No _____**

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6. **Do you currently have insurance? (If yes list information below)** **Yes _____**
   No_____

_____

_____

7. **All current doctors/physiatrist name, address, and telephone numbers (use additional form if needed)**

_____

_____

You should continue your current care for your Mental Health needs until your assessment is complete and you have been accepted in our agency for services. If a crisis situation arises and you are not currently under a provider's care, please contact the closest Emergency Department for assistance.

_____ _____

Signature/Title **Date**