Triangle Counseling Agency

P.O. Box 99036, Raleigh, NC 27624
TEL:919-277-0253, Fax:919-277-4627

Referral for Outpatient Therapy

Referral: ☐ Child ☐ Adult Prefers to meet: ☐ In Office ☐ In home

Medicaid #: _____ Medical Record #: _____

Referral Source / Phone # _____ Case manager / Phone #: _____

Reason for Referral: _____

_____

_____

_____

Child:

Name: _____
Last First Middle

Address: _____
Street City/State/Zip County

Telephone _____ Male/Female ☐ ☐ Ethnicity _____ DOB _____

School _____ Grade level _____ Special Program _____

- Parent Name(s)**:** _____ Address: _____

  Telephone: Home # _____Work/Cell # _____Best Time To Call _____

Adult:

Name: _____
Last First Middle

Address: _____
Street City/State/Zip County

DOB _____ Male/Female Ethnicity _____ Occupation _____

Telephone: Home # _____ Work/Cell # _____ Best Time To Call _____

- Guardian (if applicable): _____ Guardian Telephone: _____

  Address: _____ Relationship to client _____

Please complete the child or adult referral and fax the completed information along with any applicable release of information to (919) 277-4627. Please include any active Orders for Service if present in client's file.