Harmony Health, PLLC Therapeutic Services
5820 East W.T Harris Blvd Ste 205 Charlotte, NC 28215
704-469-1243 P
704-469-1713 F

Referral Form

Date: _____

Referral Source: __ Self __ DSS/YFS __ DJJ __Court __ Agency __Primary Care __ Law Enforcement

__ School __ Other: _____

Contact Name: _____ Phone #:_____

Email: _____

Client Name: _____ Phone #:_____

Client's Parent/Legal Guardian: _____ Contact#: _____

Client/ Legal Guardian Email: _____

Client Address: _____

DOB: _____ Age: _____ Race:_____

Disability: __ Yes __ No

Billing: __ Self Pay __ Insurance

Medicaid/Insurance #:_____ Provider: _____

Reason for Referral:

_____

_____

_____

Triage Severity of Need:

Is this referral urgent? [within 48hrs] ☐ Yes ☐ No

Is this referral routine? [within 10 days] ☐ Yes ☐ No

Email or fax Referral Form to: Fax to 704-469-1713, Or Send SECURE EMAIL TO: Intake.HarmonyHealthPLLC@gmailcom

To be completed by Agency Staff:

__ Client Appropriate Assessment Scheduled: __ Yes __ No Date: _____

__ Client Not Appropriate Reason: _____

If not; (Referred to): _____