Initial Contact Date: _____ Appointment Date:_____ Staff Initials: ____
Level of Urgency:☐ Routine (7 days), ☐ Urgent (48 hrs), ☐ Emergent (24 hrs)

ALLC Inc.

Behavioral Health Screening/ Referral Form

Contact Info

Date: _____ Referring Person/Agency_____

Address: _____ Phone: _____

City/State/Zip: _____ Fax: _____

Consumer Information

Full Name: _____ **DOB**: _____

Address: _____ Home #: _____

City/State/Zip:_____ Work #: _____

Contact Person/Guardian:_____ Phone: _____

Insurance: _____**Medicaid/County#**:_____

School or Employer: _____

Diagnosis: _____ Medication(s): _____
_____ _____

Presenting Problem/Need:_____
_____
_____
_____

Prior MH treatment:_____
Primary MD:_____ Phone: _____
Psychiatrist: _____ Phone: _____
OP Therapist:_____ Phone: _____

Access To Care:

	Life-Threatening emergency (to be seen immediately/within 1 hour)
	Non-Life-Threatening emergency (to be seen in 2-6 hours after phone de-escalation)
	Urgent (to be seen within 48 hours)
	Routine (to be seen within 7 calendar days)

Initial Contact Date: _____ Appointment Date:_____ Staff Initials: ____
Level of Urgency:☐ Routine (7 days), ☐ Urgent (48 hrs), ☐ Emergent (24 hrs)

Disposition to be determined by Licensed or Qualified Professionals Only:
Evaluation of agency's ability to provide a service

☐ Referred for Intake: YES ☐ NO ☐ **Intake date:** _____
☐ Referred Program: ☐ SACOT ☐ SAIOP ☐ IIH ☐ OPT ☐ CAP ☐ IPRS ☐ Peer Support
☐ RES Level 1☐ 2☐ 3☐
☐ Client not Available or Unable to Continue Treatment (relocated, currently institutionalized or incarcerated, Death [per program specifications])
☐ Refuses/Declines Treatment (client or legally responsible person)
☐ Medicaid Inactive and/or Not eligible: [WHY?]

- Out of County _____
- Lapse in coverage _____
- Does not cover the service needed _____

☐ Medicaid Active and Eligible:
☐ Linkage provided to: _ _____ Date: _____

Contact /Activity Amount of Time
I certify that local community resources have been investigated and/or consulted to determine whether or not any of them can furnish appropriate and necessary care. I have seen this individual and have evaluated him/her and his/her situation. I have also considered alternate modes of treatment. All community resources have been investigated and are not available if hospitalization is recommended.

Intake personnel signature: _____ Date: _____

Consumer Advocate signature: {if Applicable} _____ Date: _____

Licensed and/or Qualified Professional signature: _____ Date: _____

In efforts to continue to be able to assist others in need of our services, we would like to know how you found out about our programs/services. Please answer the following questions below. If you need help filling out this form, please ask a representative of ALLC for assistance.

How did you hear about ALLC?

☐My Doctor ☐A Friend ☐Outreach worker ☐Our Website ☐Family Member
☐Word of Mouth ☐Community Agency ☐ DSS ☐Business Card ☐other

Thank you!

ALLC Inc.
133 Union Street South
Concord, NC 28025
Phone - 980-270-5500
Fax - 980-982-0672