



Memphis Location      p: 901-346-1270      e: [areece@camelotcare.com](mailto:areece@camelotcare.com)  
Bolivar Location      p: 731-403-0007      e: [wmiller@camelotcare.com](mailto:wmiller@camelotcare.com)  
Covington Location    p: 901-229-8924      e: [bpitts@camelotcare.com](mailto:bpitts@camelotcare.com)

### Referral Form

Date: \_\_\_\_\_ Referral Agency/Name: \_\_\_\_\_

Referral Source's Email: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Please Check One:**

<input type="checkbox"/>	<b>Intensive In Home (CCFT)</b>	<input type="checkbox"/>	<b>Case Management</b>	<input type="checkbox"/>	<b>Outpatient (Indv. or Group)</b>
<input type="checkbox"/>	<b>Med Management</b>	<input type="checkbox"/>	<b>Intensive Outpatient</b>	<input type="checkbox"/>	<b>Supervised Visitation</b>
<input type="checkbox"/>	<b>A&amp;D Assessment</b>	<input type="checkbox"/>	<b>DUI School</b>	<input type="checkbox"/>	<b>Other:</b>

Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Male Female  
Social Security #: \_\_\_\_\_ Race: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_ Contact Phone # (\_\_\_\_) \_\_\_\_\_  
Insurance Co: \_\_\_\_\_  Self-Pay  Other: \_\_\_\_\_  
**\*\*The family will be notified within 24 hours or shortly thereafter. Referents will be notified of status\*\***

Describe the current situation and behaviors leading to the referral: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Camelot Use Only:**

Insurance Co.: \_\_\_\_\_ Effective Dates: \_\_\_\_\_ to \_\_\_\_\_  
Member I.D. #: \_\_\_\_\_ Co-pay: \_\_\_\_/\_\_\_\_  
Deductible: \_\_\_\_/\_\_\_\_ Max Out-of-Pocket: \_\_\_\_\_ Payout: \_\_\_\_\_ %  
Prevention Program(s): \_\_\_\_\_  
Max units/days allowed per Calendar Year: \_\_\_\_\_ Calendar Year Max Used to Date: \_\_\_\_\_  
Admit Diagnosis Code: \_\_\_\_\_ Licensed Practitioner: \_\_\_\_\_

Appt. Date(s) Offered: \_\_\_\_\_ Appt. Date Accepted: \_\_\_\_\_

Reason for Delayed Appointment (If First Appointment Date is out of Access Standard Time Frame): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Resources Offered (If Camelot Services are Refused): \_\_\_\_\_

Camelot Team Member \_\_\_\_\_ Date \_\_\_\_\_  
Revised 11/15