



Kingsport Location

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Referral Form

Date: _____ Referral Agency/Name: _____

Referral Source's Email: _____ Phone #: _____ Fax #: _____

Please Check One:

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

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