2460 Delaney Ave
Wilmington, NC 28403

CAPE FEAR
DEVELOPMENTAL THERAPIES

910-202-9113 (Office)
910-202-9289 (Fax)

Date of Referral: _____

Name of Agency/Referring Provider: _____

Contact Information of Referring Provider [Phone/Fax/Email]:_____

_____

Patient Name: _____ DOB: _____

WHO has MEDICAL DECISION-MAKING RIGHTS for the client? *(circle all that apply)*

Biological Mom Biological Dad DSS (County)_____ Other: _____

Parent/Guardian Name:_____ Phone #:_____

(If DSS has custody, please provide name & contact number for current social worker and supervisor.)
If the child/adolescent is not in biological parent custody or biological parents are not together, scheduling will not occur until current custody documents are provided.) PLEASE SEND THIS DOCUMENTATION WITH REFERRAL .

Current Patient Address: _____

Resides with (*list all adults living at above address)*:_____

Insurance Provider: _____

REFERRAL DETAILS: (NOTE: This section MUST be completed entirely, or referral will be denied)
*** REFERRALS MUST CONSTITUTE A MEDICAL ORDER FOR TESTING OR THERAPY. PLEASE BE SPECIFIC IN THE QUESTIONS YOU WOULD LIKE ANSWERED, THE GOAL OF THIS EVALUATION, AND HOW THE RESULTS WILL BENEFIT YOUR CLIENT'S TREATMENT***

***PLEASE ATTACH MOST RECENT AND RELEVANT medical note or Comprehensive Clinical Assessment to this referral and any relevant medical and education paperwork.**

Fax or email to 910-202-9289 or cfkidstherapy@gmail.com.

We will send follow-up confirmation as soon as possible. Thank you for your collaboration!