2601 Iron Gate Drive, Suite 101
Wilmington, NC 28412

CAPE FEAR
DEVELOPMENTAL THERAPIES

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

Date of Referral (actual date sent): _____

Name of Referring Agency and Provider:_____

Contact Information for Referring Provider [Phone + Fax + Email] – and is this PCP?_____

_____

(we may have to request an additional referral from the child's / adolescent's PCP)

Patient Legal Name: _____ **DOB:** _____

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

Bio/Adoptive Mom **Bio/Adoptive Dad** **DSS** (County)_____**Guardian** (specify)_____

Parent/Guardian/DSS SW Names:_____ *(If DSS custody, name of Social Worker & supervisor.)*

Phone #s:_____

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 THAT DOCUMENTATION WITH REFERRAL.

Current Patient Address (resides with): _____

_____

Insurance Provider (specific plan if Medicaid): _____

REFERRAL DETAILS: (NOTE: This section MUST be completed with some detail, or referral will be denied)

REFERRALS must constitute a MEDICAL ORDER of "medical necessity" for TESTING OR THERAPY. PLEASE BE SPECIFIC in the questions you would like answered, the goals of the requested evaluation, and how the results will impact treatment.

_____

******ATTACH most recent / relevant medical note or CCA, and if possible, any educational records.******

Referrals are accepted by FAX ONLY - 910-202-9289

For questions you may call: 910-202-9113 ext 100.