Coastal Horizons Center, Inc.

Clínica Latina & Child Mental Health Services
Tel: 910-343-0145 or 910-524-1034

REFERRAL FORM

Name: _____

Age:_____ **DOB:**_____**Grade:**_____ **School:**_____

Address: _____

Parent/Guardian: _____

Tel: _____

Medicaid: ☐ **Health Choice:** ☐ **Self-Pay:** **Other:**_____

Referring Agency: _____
_____

Contact Person:_____

Tel:_____**Fax:** _____

Reason for Referral:

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Case Management: **YES** ☐ **NO** ☐
Who:_____
Tel: _____

DSS: **YES** ☐ **NO** ☐
Who:_____
Tel:_____

Court Counselor: **YES** ☐ **NO** ☐
Who:_____
Tel:_____

Diagnosis:_____
_____
_____

Medications:_____
_____
_____

Please Fax Referral Form to: (910) 341-5779