Coastal Horizons
CLINICA LATINA

Child & Adolescent Treatment Services

Please fax REFERRAL FORM To: 910- 341-5779

Date ____/____/_____

Name: _____ **Male** ☐ **Female** ☐

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

Address: _____

Parent/Legal Guardian: _____

Tel: _____

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

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: _____

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

OTHER: _____

_____

_____

Clinica Latina's Phone Number - 910-343-0145

Thank You