Wake County, North Carolina
referral@wellspringintervention.com
Licensed under 10A NCAC 27G .1700

Referral & Intake Request Form

For referring professionals, LME/MCOs, and county DSS

Form ID: WSI-F01

REFERRING PARTY INFORMATION

Referrer Name: _____ **Agency:** _____

Title / Role: _____ **Phone:** _____

Email: _____ **Date of Referral:** _____

Referral Source (LME/MCO, DSS, Other): _____

CHILD / ADOLESCENT INFORMATION

Child's Name: _____ **Preferred Name:** _____

Date of Birth: _____ **Age:** _____

Sex: _____ **Gender Identity:** _____

Race / Ethnicity: _____ **Primary Language:** _____

Current Address: _____

CLINICAL SUMMARY

Primary Diagnoses (DSM-5 / ICD-10):

Current Medications:

Behavioral Concerns / Reason for Referral:

Trauma History (summary):

AUTHORIZATION

By signing below, I confirm that the information provided is accurate and I am authorized to make this referral.

Referrer Signature	Printed Name	Date