BURKE COUNCIL ON ALCOHOLISM & CHEMICAL DEPENDENCY, INC.
203 White Street, Morganton, NC 28655
828-433-1221 (Phone) 828-433-1287 (Fax)

CLIENT REFERRAL FORM

Date: _____

Client Name: _____

Address: _____

_____

Phone: _____

Age: _____ DOB: _____ Gender: M: ____ F: ____

Medicaid: Y: _____ N: _____ #: _____ (attach copy of card)

Referring Agency: _____

Person making referral: _____

Phone: _____

Purpose of referral: SA Assessment: _____ Outpatient therapy: _____

NOTE: if assessment has already been done by referring agency or other agency, please forward a copy of assessment to BCACD at (FAX) 828-433-1287

Brief statement of problem/reason for referral:_____

_____

Source of payment: Medicaid: _____ State Funds (IPRS): _____ Self-pay: _____

Other: _____

PLEASE NOTE: Client is responsible for the full cost of an assessment as well as any treatment fees if client does not have Medicaid or does not qualify for state funding. Payment for services is expected at the time services are provided. We use a sliding scale to determine payment amount (income documentation is required).