CONSUMER REFERRAL

I have been informed that I would benefit from the services ARJ, LLC provides. I would like to inquire about the services available and give the referring agency the authority to disclose any necessary information to ARJ, LLC in order to make the process a smooth transition.

The service(s) that I have been encouraged to enroll into with ARJ, LLC are as follows:
-Please place an **X** *to all that apply-*

Child/Adolescent Services: Diagnostic Assessment: ☐ Intensive In-Home: ☐ SAIOP: ☐ Outpatient Therapy: ☐

Adult Services: Diagnostic Assessment: ☐ Community Support Team: ☐ SAIOP: ☐ Psychosocial Rehabilitation (PSR): ☐ Outpatient Therapy: ☐

Consumer's Name *(Please print)* | **Phone # (home or cell)**

Consumer's Address | **City** | **State** | **ZIP**

Medicaid ID # | **Social Security #** | **D.O.B. #**

Physician's Name | **Office Number** | **Address**

Reason for Referral:

Consumer's Signature (Parent/Guardian) | **Date** M D Y

Referring Agency's Staff | **Date** M D Y

Please FAX to our secure lines:

Greensboro, NC:	Charlotte, NC:	New Orleans, LA:
(336) 763-0316	(980) 819-5694	(504) 324-8692