Adventure House
924 N. Lafayette Street
Shelby NC 28150
Phone: 704-482-3370
Fax: 704-482-3383

Adventure House
Referral

North Carolina Division of Mental Health
Developmental Disabilities, and Substance
Abuse Services

Client's Name: **Partners BHM ID:**

Address _____ Social Sec. # _____ Date of Birth _____
_____ Race _____ Sex _____
Phone # _____ Education _____ Guardian Yes No
Medicaid# _____

Emergency Contact/Guardian Name, Address and Ph. #_____

Printed Medical Dr/Nurse Practicioner Name _____ Ph _____

Printed Psych Dr Name _____ Ph _____

Behavioral Health Providers Name _____ Ph _____

Current Diagnosis

	Diagnostic Code	DSM Description
PRIMARY		
SECONDARY		
MEDICAL		
PSYCHOSOCIAL		

Present condition of client reported in objective behavioral terms:

_____
_____
_____

Reason for referral:

	Basic Living Skills		Socialization/Communication Skills (Interpersonal Skills)
	Employment Support		Supported/Independent Living
	Money Management Skills		Prevocational Training
	Decrease Isolation		Education Support
	Maintain MH Stability		Work/Leisure Balance
	Decrease Hospitalizations		Managing Symptoms that Interefere with Reintegration
	Maintain Current Level of Independence/Self-Care Support		

*****Attention Referral Source:**

If you are a Behavioral Health Provider, please include an updated copy of the Diagnostic Assessment/CCA to support Medical Necessity and an updated PCP that has PSR as a goal. Forms may be submitted in person or by mail @ 924 N Lafayette St, Shelby NC 28150 or fax @ 704-482-3383

_____ _____
Date of Referral Printed Name of Referral Source

Referral Source Agency Name _____
Address _____
Phone # _____
Fax# _____
Email Address _____

Adventure House Use Only

☐ Approved Date of Approval _____ Comment _____
☐ Denied Reason for denial _____
_____

Form No. AHR/SO 02/27/2023