McLeod Addictive Disease Center
Adolescent Treatment Services
Referral Form

Fax to 704-335-8685
Attn: Angela M. Pettit BS, CSAC

Date of Referral:	Client:	
Age:	Legal Guardian:	Insurance provider:
Address:		
Telephone #:	County of Residence:	

Referring Person:	Relationship to Client:
Agency (if applicable):	
Agency Address:	
Telephone #:	Email Address:
Reason for Referral:	

Please include the following information if applicable:

Substance Use:
Criminal Justice Involvement:
Other Service Providers Involved:
Educational Status: If enrolled required proof of enrollment
Mental Health Issues and Medication Regimen:
Previous Treatment Episodes:

Please provide the following documents:

Most recent Comprehensive Clinical Assessment:
Most recent drug screen results:
Most recent Person Centered Plan:
Comments: