

Referral for Psychiatric Evaluation
Smoky Operated Services / Balsam Psychiatric Clinic
91 Timberlane Road, Balsam, NC 28785
Intake Phone: 828-454-7220 ext 2823
Intake Fax: 877-415-7856

Please indicate your recommendation: _____ **ROUTINE** _____ **URGENT**
(Please note, all referrals designated as “urgent” will be reviewed by a clinician prior to scheduling and will be scheduled according to clinical acuity. Appointments will be scheduled directly with consumers. If you make an “urgent” referral and we are unable to schedule the appointment within 2 weeks either due to volume or other reason - you will be notified by telephone.

Consumer Name: _____ **Record #:** _____

Date: _____ **Referred By:** _____ **Phone #:** _____

Consumer phone #: (HOME): _____ **(CELL):** _____ **(OTHER):** _____

DOB: _____ **Residing County:** _____ **Insurance:** _____

Guardian: _____ **Guardian Phone:** _____

Reason for Referral (symptoms/behaviors needing to be addressed): _____

Past/current diagnosis (if known): _____

Current medications with prescriber’s name (if any): _____

Other services being provided: _____

Please note: referrals received without a completed assessment will not be processed.