2114 Dabney Road Suite B
Richmond, Virginia 23230
804-340-6585
www.born2bgreat.org

PRE-SCREENING & REFERRAL FORM

Client:

REFERRER INFORMATION	
Complete this form and fax it to 804-325-3319	
Referred by:	**Date:**
Address:	**Phone:**

SERVICES NEEDED (Check All that Apply)
☐ **Substance abuse case management services**
Reason why the individual is receiving services:

CLIENT INFORMATION		
Client Name:	**DOB:**	☐ **Male** ☐ **Female**
Address:	**City:**	**Zip:**
Telephone: (C)	**Message Phone:**	**Last 4 of SSN:**

BILLING INFORMATION (IF APPLICABLE)
Primary Insurance Company:
Virginia DMAS Medicaid #:

CONSENT

By signing my name below, I certify that I have read the above information. All questions concerning the scope and level of services has been discussed. My signature also certifies my understanding of an agreement with the above information. I hereby authorize Born To Be Great II to disclose the following information about me for the purpose of providing me with service coordination. I understand that I may revoke this consent at any time in writing, but that revoking it will not cancel what was already done before I revoked it. I understand that I have the right to inspect and copy the information to be disclosed. If not previously revoked, this consent will terminate upon completion of the service coordination, but in no event shall exceed one year from today.

Signature of Client: _____ **Date:** _____

Signature of Parent, Guardian, or Authorized Representative
(If appropriate) _____ **Date:** _____

DISPOSITION OF REFERRAL (B2BG) STAFF ONLY: