23 Eastbrook Bend, Suite 200, Peachtree City, GA 30269
2 Lee Street, Suite A, Newnan, GA 30263
Phone 770-486-1140 Fax 678-669-2693
www.graceharbour.net

Grace Harbour, Inc.
Referral Form
Date of Referral: _____

Client's Identifying Information

Please fill out as much information as possible

Name(Last, First Middle Initial):			**DOB:**
Address:	**City:**	**State:**	**Zip Code:**
Phone Number:	**Alternative Number:**		
SS#:	**Gender: ☐Male ☐Female**	**School:** (If applicable)	**Grade:** (If applicable)
Parent or Legal Guardian's Name:		**Phone Number:**	
Race:☐ American Indian/Alaskan Native ☐Native Hawaiian/other Pacifc ☐ Black/African American ☐ Asian ☐ White/Caucasian ☐Other Single Race ☐Islander ☐Multiracial		**Hispanic/Latin Origin: ☐Yes ☐No**	
Marital Status: ☐Single (never married) ☐Separated ☐Divorced ☐Married ☐Widowed			
County where services are requested:			
Who will be paying for services: ☐Referring Agency ☐Private Insurance ☐Client ☐Medicaid ☐Unknown Type: _____ Number:_____			

Referral Information

Referral Contact Name:	**Phone Number:**
Email Address:	**Supervisor's Name:** (if applicable)

Reason for Referral

Please state individual's circumstances and reason surrounding the request for services:

****Please note that once the initial intake has been completed, the case will be staffed to determine what clinical services are recommended and what will be covered by the insurer.****