

**Friendship Center Treatment Referral Form**

**3809 Rosewood Drive**

**Columbia SC 29205**

**Phone: (803) 786-1844**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ CID: \_\_\_\_\_ Phone: \_\_\_\_\_

Address : \_\_\_\_\_  
Street Address City State ZIP

D.O.B. \_\_\_\_\_ Education: \_\_\_\_\_

Please Check: Medicaid: \_\_\_\_\_ Medicare: \_\_\_\_\_ Self Pay: \_\_\_\_\_ Other: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
Name Phone Number(s)

\_\_\_\_\_  
Name Phone Number(s)

Referred By: \_\_\_\_\_ Phone Number: \_\_\_\_\_

If not referred by Case Manager Please provide the following:

Case Manager: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Psychiatrist Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Multi-Axial Information:

Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

Axis V: \_\_\_\_\_

**Brief History:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Date of Most Recent Hospitalization:** \_\_\_\_\_

**Medications:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please Indicate What Type of Treatment Is Required:**

**PRS:** \_\_\_\_\_ **Ind.Tx:** \_\_\_\_\_ **Gr.Tx:** \_\_\_\_\_

**Reason for Treatment Referral:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Please attach current Plan of Care with Referral.*

**Thank you for your interest in the Friendship Center. Please remit through interoffice mail to MIRCI Friendship Center or you can use our mailing address. You can also fax the form to us, Fax Number: (803) 754-7783.**