

# REFERRAL FORM

Pre-Trial Intervention  
Phone: 843-537-0532  
Fax: (843)-537-0562

121 Market Street  
Cheraw, South Carolina 29520

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ PERSON REFERRED \_\_\_\_\_

ADDRESS: \_\_\_\_\_ SC, \_\_\_\_\_  
Street, PO Box, Apt. City/Town Zip Code

DOB: \_\_\_\_\_ SS# \_\_\_\_\_

TELEPHONE (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Other) \_\_\_\_\_

Fourth Judicial Circuit will require that the following agencies listed below will provide information regarding attendance, progress, level of participation, and discharge status, the person referred should be instructed to sign a Consent of Release of Confidential Information designating the person(s) to whom information is to be provided.

- |   |   |
|---|---|
| <input type="checkbox"/> The Alpha Center                   | <input type="checkbox"/> Tri-County Mental Health       |
| <input type="checkbox"/> Robert Smalls Family Life Center   | <input type="checkbox"/> S.C. Vocational Rehabilitation |
| <input type="checkbox"/> Chesterfield Marlboro EOC One Stop | <input type="checkbox"/> Hi-TeK                         |
| <input type="checkbox"/> Care South Carolina                | <input type="checkbox"/> Sand Hills Medical Center      |
| <input type="checkbox"/> Bennettsville Workforce Center     | <input type="checkbox"/> Trinity Care                   |

Services Requested: \_\_\_\_\_ PTI \_\_\_\_\_ AIP

DOCUMENTS/INFORMATION to be provided, if any \_\_\_\_\_

**Referring individuals/ organizations will inform persons referred that:**

- With some exceptions, agency charges fees for services rendered but do not refuse services due to inability to pay; clients will be held responsible for agreed upon charges;
- This facility is accessible to persons with disabilities;
- Family members/significant others will participate in the treatment process as appropriate.

Referring Agency \_\_\_\_\_ Telephone: \_\_\_\_\_

Referral Agent Signature \_\_\_\_\_ Title \_\_\_\_\_

**Records and Release information Release Authorization**

I, \_\_\_\_\_ grant permission for release of information to the above checked agency.

Signature of Person Referred \_\_\_\_\_ Date \_\_\_\_\_