William J. McCord Adolescent Treatment Facility

910 Cook Road P.O. Box 1166
Orangeburg, SC 29116
(803) 534-2328 Fax: (803) 531-8419
Web Address: www.tccada.com
E-mail address: sjohnson@tccada.state.sc.us
jshaw@tccada.state.sc.us

Referral Form

Date: _____

Name of Referred: _____ Date of Birth: _____

Address: _____ City: _____ County: _____ Zip code: _____

SS #: _____ Sex: _____

Parent/Legal Guardian: _____ Relation to client: _____

Home/Cell Telephone #: ( ) _____ Work #: ( ) _____

Name of person making referral: _____ Telephone #: ( ) _____

E-mail Address: _____ Referring Agency:_____

DSS Involvement: _____

DSS Caseworker: _____ Tel. #: ( )_____

DJJ Involvement: _____

DJJ Officer: _____ Tel. #: ( )_____

DSM 5 Diagnoses: . .

_____

_____

_____

Psychosocial and Environmental Factors:_____

_____

Reason Referred for Inpatient Treatment: _____

_____

_____

_____

_____

Psychiatric Problems: _____

_____

Medications (name & dosage): _____

History of Violence: _____

Suicide Attempts: _____

Prior Counseling/Treatment Facility: _____

Type Tx: Outpatient _____ IOP _____ Inpatient _____

Dates of Counseling/Treatment: _____

Payment/Guarantor Information

Medicaid #: _____

Insurance Company: _____

Policy Holder Name: _____ Policy Holder SS #:_____

Policy Holder Birthdate: _____ Group #: _____

Policy Holder/Guarantor Employer: _____

Guarantor Work Address: _____ Guarantor Work Telephone #: ( ) _____

Benefits Tel. #: _____

Precertification Tel #: _____

Secondary Insurance: _____

Total Family Income: _____per week/ every other week/ month/ year.

Total number of people living in house: _____

School Information

Name of School currently attending or last school attended: _____

Please circle one: still attending expelled suspended dropped out

Date last attended: _____

To better assist McCord Center staff in determining if this adolescent meets Inpatient Criteria, the following information should be faxed or mailed to Sabrina Johnson or Jennifer Shaw at the address listed on the front of this document.

Most recent Clinical Assessment
Last R & E Report
Copies of all drug screens
Most recent Psychiatric/Psychological Evaluation
Copy of Medicaid/Insurance Card/W-2 form or Paycheck
Records from physician/agency prescribing medications

10/15 md