Blue Ridge Opportunities
Referral/Initial Contact for Services

Individual Name_____ Date_____

Age_____ Gender_____ Medicaid#_____

Address:_____

Phone Number:_____

Email_____

Initial Contact by: _____

Relationship to Individual_____

Nature of Inquiry/ Reason for Requesting Services

_____
_____
_____
_____

_____Walk-Thru Scheduled [date] _____

Disposition/Appropriateness of Services

_____
_____
_____
_____
_____

_____ **Accepted** _____ **Wait-Listed**

_____ **Denied and Referred to other resources**

_____ Referred to CSB

_____Referred to _____

_____Referred to _____

Agency Intake Representative:_____

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