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: pgolden@tccada.org
eloper@tccada.org

Referral Form

Date: _____

Name of Referred: _____ Date of Birth: _____

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

SS #: _____ Sex: _____ Race:_____

Parent/Legal Guardian: _____ Relation to client: _____

Telephone #: (___)_____ Parent/ Guardian email:_____

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

Email Address: _____ Referring Agency: _____

DSS Caseworker name & email: _____ Tel. #: (___)_____

DJJ Officer name & email: _____ Tel. #: (___)_____

DSM 5 Diagnoses: _____
_____
_____
_____

Psychosocial and Environmental Factors: _____
_____

Reason referred for Inpatient Treatment: _____
_____
_____
_____
_____
_____
_____

Psychiatric Problems: _____
_____
_____
_____
_____
_____

Medications (names & dosage) :_____

_____

History of Violence:_____

_____

Suicide Attempts: _____

_____

Prior Counseling/ Treatment Facility: _____

_____

Medicaid

Medicaid #: _____ MCO:_____DOB:_____

Insurance

Insurance Company: _____

Policy Holder Name: _____ Policy Holder SS #:_____

Policy Holder date of birth: _____

Policy Holder/Guarantor Employer: _____

Policy Holder work address: _____

School Information

Name & District of School currently attending/ last attended:_____

_____

Name, Number, Email of Homebound Coordinator: _____

To assist McCord Center staff, the following documents need to be included with the referral to determine if the adolescent meets inpatient criteria:

-Most recent psychiatric/psychological evaluation
-Records from the physician/agency prescribing medications
-Most recent clinical assessment
-Copies of all drug screens
-Copies of Medicaid/Insurance cards
Please submit referral and documents to:

Pamala Golden- pgolden@tccada.org Erin Loper- eloper@tccada.org Fax #: 803-531-8419