

Nexus Care
OF BEAUFORT COUNTY
Healthy People. Thriving Communities. Brighter Futures.

REFERRAL FORM

Name: _____ Date: ____/____/____

Service Location: ☐ Beaufort ☐ Bluffton/ Hilton Head Island

SS#: _____ - _____ - _____ DOB ____/____/____ Age _____ Preferred Gender: _____

Phone: Cell (____) _____ - _____ Phone: Work (____) _____ - _____

Email _____@_____.com

Physical Address: _____ OK to send Mail ____Y ____N

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____

Phone: (____) _____

Bring your Identification and insurance card to the Appointment.

Please Circle your answer:

Do You Have Medicaid: Yes / No Medicaid # _____

Other Insurance _____ or No Insurance

Please Bring proof of Income if you would like to apply for Financial Assistance

REFERRED BY

Name _____ Date ____/____/____

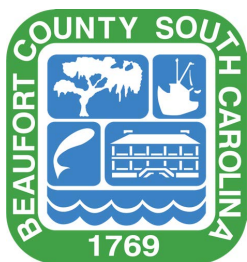
Phone: (____) _____ - _____ Release of Information Signed ____Y ____N or NA _____

Email _____@_____.com

Reason: _____

PLEASE FILL OUT THE BACK OF THIS PAGE





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SCREENING QUESTIONS

Do You Use (circle One) Tobacco or Vape Status Never Former Current

What Alcohol and /or Drugs do you use? _____

When was your last use? _____ How Much? _____

Since your last use (or when not using), HAVE YOU HAD:
PLEASE CHECK ALL THAT APPLY

_____ Difficulty Sleeping

_____ Shaking

_____ Nausea/vomiting

----- Diarrhea

----- Racing Heart

_____ Increased Appetite

_____ Mood Swings

_____ Sweating

_____ Fatigue (Very Tired)

Physical Address: _____ City _____ Zip code _____

Mailing Address: _____ City _____ Zip code _____

Marital Status _____ Race _____ Ethnicity _____

If You are a Female, Are you Currently pregnant ____ Yes ____ No

Have you served in the military? _____

How Many in the household _____ How Many under 18 years _____

Highest Level of Education _____

Employment Status: Circle One Full-Time Part-Time Disabled Unemployed

Occupation _____ Annual Salary: \$ _____

Please Email to: bcadadreferral@bcgov.net