

Friendship Center Drop-In Referral Form

3809 Rosewood Drive

Columbia SC 29205

Phone: (803) 786-1844

Date: _____

Name: _____ CID: _____ Phone: _____

Address : _____
Street Address City State ZIP

D.O.B. _____ Education: _____

Please Check: Medicaid: _____ Medicare: _____ Self Pay: _____ Other: _____

Emergency Contact: _____
Name Phone Number(s)

Name Phone Number(s)

Referred By: _____ Phone Number: _____

If not referred by Case Manager Please provide the following:

Case Manager: _____ Phone Number: _____

Psychiatrist Name: _____ Phone Number: _____

Date of Most Recent Hospitalization: _____

Medical Information: _____

Allergies: _____

Thank you for your interest in the Friendship Center. Please remit through interoffice mail to MIRCI Friendship Center or you can use our mailing address. You can also fax the form to us, Fax Number: (803) 754-7783.