Phone: (833) 496-0445 Fax: (984) 208-5220 | 415 Dunstan Ave. Durham, NC 27707

PATIENT REFERRAL FORM

The therapy and counseling work we do is unique to you, just as it is to each one of our clients. Before your first visit, we need to collect some general information from you.

Date _____ Referral Source _____

GENERAL INFORMATION

Client Name _____ Date of Birth _____

ADDRESS

_____

House Number Apt Street City, State ZIP County

Telephone _____ Gender: Male Female Other: _____ Ethnicity_____

Medicaid #: _____

Private Insurance Information:

_____

_____

Diagnosis (Code and Description) _____

Parent/Guardian _____

Telephone _____

Reason for Referral (Anger, need for mental assessment, etc.)

_____

_____

If available, please submit with the referral: Clinical Assessment (with client history), Order for Service, Copy of recent Treatment Plan, any other relevant documentation