

# Physician Referral Form To Coastal Haven Counseling

Referring Physician Name: \_\_\_\_\_

Physician Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Referral Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

Client DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

Client Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Client/Guardian Phone: \_\_\_\_\_ 2<sup>nd</sup> Phone: \_\_\_\_\_

**\*We DO NOT Accept Dual Insurance**

**\*We Accept BCBS, Most SC Medicaid Plans, Aetna, United HealthCare, and Self Pay Only**

Type of Insurance: \_\_\_\_\_

Insurance Number/Member ID: \_\_\_\_\_

Insured Name on Card \_\_\_\_\_

Insured Relationship to Client \_\_\_\_\_

Description of diagnosis or issue to be addressed:

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