



## Physician Referral Form

Please Fax To: (843) 432-3091 | *\*Only this form is needed for a referral at this time*

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

Office Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Insurance (check one): *These are the only insurance plans we accept*

All SC Medicaid Plans  Aetna  Blue Cross Blue Shield  UnitedHealthcare  Self-Pay

Plan: \_\_\_\_\_ Member ID: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Diagnosis/Issues:

Depression  Anxiety  Trauma  ADD/ADHD  PTSD  Bipolar  Autism  OCD  Grief

Panic Disorder  Couples Counseling  Social Anxiety  Specific Phobia  Substance Use Disorder

PMDD (Pre-Menstrual Dysphoric Disorder)  Post Partum Disorder  ODD (Oppositional Defiant DO)

Family Counseling  Anger Mgnt  Other: \_\_\_\_\_  Other: \_\_\_\_\_

### Reason for Referral/ Addt'l Info:

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