



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*

SC Basic Medicaid Plans Molina Medicaid Blue Choice/ Healthy Blue Medicaid Humana Medicaid

Absolute Total Care Medicaid/Centene Aetna Blue Cross Blue Shield UnitedHealthcare/Optum 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:
