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-Menstral Dysphoric Disorder) ☐ Post Partum Disorder ☐ ODD (Oppositional Defiant DO)

☐ Family Counseling ☐ Anger Mgnt ☐ Other: _____ ☐ Other: _____

Reason for Referral/ Addt'l Info:

_____

_____

_____