



Referral for Outpatient Therapy

Date of Referral: _____ Referred By / Phone #: _____

Reason for referral _____

Psychiatric Evaluation needed

Doctor/Psychiatrist _____ Phone _____

Other professional/role _____ Phone _____

Client Information

Adult Child

Prefers: In-home appt Office appt

Client Name (*First, MI, Last*) _____

DOB ____ / ____ / ____ Gender Male Female SSN: _____

Address _____ City _____ State ____ Zip _____

Phone # _____ Alternate # _____

For Children Only (please complete the following):

Parent or Guardian name(s) / Relationship _____

Phone # _____ Alternate Phone # _____

Address (if different from child's) _____

Insurance Information

Check if no insurance

Insurance Provider _____ Member Insurance _____

Policy holder _____ Relationship to client _____

For Medicaid referrals, please include the following:

Provider ID/Carolina Access #: _____ Provider NPI: _____

Please fax referrals to New Leaf Behavioral Health at (919) 781-2266