THERAPY YOUR WAY
COUNSELING AND CONSULTING SERVICES
Phone: 803-708-6014 Fax: 803-708-5315
www.therapyyourway.org

Referral Form

Patient Name:		**Date of Birth:**		**__Male ___Female**
Parent/ Guardian (if under 18):				
Address:	**City:**	**State:**	**Zip Code:**	
Contact Phone Number(s):				
Contact email address:				

Reason for Referral :

_____

_____

_____

Referring provider or Agency :

_____

Phone Number: _____ **Fax:**_____

NPI#: _____ **Tax ID#:** _____

Primary Insurance : _____

Insured's Name: _____ **Insured's Date of Birth**_____

Employer: _____ **Relationship to patient**_____

Policy #: _____ **Group#**_____

*********Please include the following with this information page **********

Release of Information and pertinent information (etc. office notes, psychological test results, current medications)