Pathways Growth & Learning Center, LLC
Fax: (803) 403-9979

Referral Form

Client Name:_____

Preferred Name:_____ Date of Birth:_____ Present Age:_____

Street Address: _____ City and State: _____ Zip Code: _____

Billing Address (if different):_____

Name(s) of Parent / Legal Guardian:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Presenting Issues:_____

_____

_____

Desire to Change (circle one): good fair poor Ability to Change (circle one): good fair poor

Support Systems:_____

Medications:_____

Side Effects:_____

Diagnosis: Axis I:_____ Code:_____

(if known) Axis II:_____ Code:_____

Axis III:_____ Code:_____

Primary Insurance: _____ Phone Number: _____

ID Number: _____ Group Number: _____

Name of Insured: _____ Insured's DOB: _____

* If Medicaid, please list 10-digit Medicaid number for Insurance ID number

Secondary Insurance: _____ Phone Number: _____

ID Number: _____ Group Number: _____

****Please attach copy of current Insurance card with this form****

Primary Care Physician:_____ Phone:_____

Name of referring licensed professional:_____ Relationship to client:_____

NPI of referring licensed professional:_____

Referring Organization:_____

Street Address: _____ City & State:_____ Zip Code:_____

Work Phone:_____ Fax:_____

Form must be **fully** completed and approved by Pathways Growth & Learning Center, LLC **before** client's appointment.

Appt. Info: Day/Time: _____ Therapist: _____