

REFERRAL FOR BEHAVIORAL HEALTH OUTPATIENT SERVICES

ANDERSON COUNSELING AND CONSULTING GROUP, PLLC

2315 East WT Harris Blvd, Suite 102, Charlotte, NC 28213

Office: 704-208-4458 Fax: 866-309-6385

Referral Information

_____ Charlotte Office

_____ Davidson Office

_____ Other: _____

Referral Date: _____ **Referred By:** _____

Client Name: _____ **Client Gender:** _____

Client Age: _____ **Client Grade:** _____ **Client DOB:** _____

Client SS #: _____ **Ethnicity:** _____

ETHNICITY CODES: B-Black, W-White, A-Asian, AI-American Indian or Alaskan Native, H-Hawaiian or Pacific Islander, HL-Hispanic/Latino Origin, U-Unable to Determine

Service(s) Requesting: Case Support Services Peer Support Services
 Comprehensive Clinical Assessment Individual Therapy Family Therapy Couples Therapy
 Medication Management Group Therapy Other : _____

Primary Insurance: No Yes **Name:** _____ **Policy #:** _____

Secondary Insurance: No Yes **Name:** _____ **Policy #:** _____

Parent/Guardian Name: _____ **Relationship:** _____ **Phone:** _____

Emergency Contact _____ **Relationship:** _____ **Phone:** _____

Address _____ **City:** _____ **State:** _____ **Zip** _____

Home: _____ **Work:** _____ **Cell:** _____ **Email:** _____

PRESENTING PROBLEMS

(Check all that apply)

Physical Neglect Sexual Emotional Substance Abuse Other: _____

BRIEF NARRATIVE

Please email completed form to: accgadmin@acounseling.net or Fax to 1-866-309-6385